# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0008

ngnnl

	1	For State Registrar	State of Me	arylanu /		tificate of		WEIRAIT	Reg.	.No.	000	
hydiolon	•	. Decedent's Name (First, Middle, L	ast)	_				2. Date of Month	Death	Day Year	3. Time of I	
sician edical		CHARLOTTE L. RIEL						MAR	18,	2008	0108	M
miner		a. Fecility Name (If not institution, g					or Location of Dea	ith	į	4c. County of Dea		
	-	MONTGOMERY GENERAL I , Social Security Number 6.		e (In yrs. last	hirthday)	OLNE		s. 8 Date of	Birth	MONTGOME 9 Bird	hplece (State or	Foreign
il r		136.03.1155  Jsuel Residence of Decedent	1□ M 2/D/F	89	Yrs.	Months Days			31,	9ar) Co	NJ	
	-	Oa. State 10b. County	·	10c. City, To	own or Lo	cation					10d. Inside Cit	y Limits
tor		MD HOWARD		МТ.	AIRY						1 🗆 Yes	2/1/No
Director	1	0e. Street and Number				10f. Zip Code			10g	. Citizen of What Co	untry?	
aio		688 RIDGE RD.				21771				USA		
Funeral	1	1. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of If Yes, specify Cul	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or rto Rican, etc.)	No-	14. Race - Ame Black, Whit		
þ		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes, \$\text{\text{\text{M}}} \\ If Yes, Give Year or Dates:	No		1 □ Yes 2 No	Specify:			Specify: \	ITE	
eted		15. Decedent's (Specify only highest of	Education grade completed)	1:	6a. Deced	dent's Usual Occu	pation during most of we	orking	16	b. Kind of Business	/Industry	
Completed	-	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retir	ed)					
		12. 17. Father's Name (First, Middle, La	net!		HONE	EMAKER	18. Mother's Na	ame /First Min	idle Ma	OWN HOME		
Be			3()									
10		HUGO METSEL  19a. Informant's Name/Relationship	(Type, Print)	1	19b. Mailir	ng Address (Stree	MARY 50		mber, C	City or Town, State,	Zip Code)	
	1	CHARLES J. RIEL	GP.AHDS	1			IT. AIRY, F					
	2	20a. Method of Disposition	_	20b. Place	of Dispo	sition (Name of matory or other pl		Date	20	c. Location - City or	Town, Stete	
		1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe			•	EMATORY IN		19,2008	8.	ALTIMORE, M	D	
-	T	21. Signature of Funeral Service, and	1.	) ii01148	F 1	Name and Addi	ess of Facility L HOME, P.A	A. 4 SHONIE	110	21051		
	+	23a. Pert Enter the disease, or of shock or heart failure. List of									Approximate Interval Bety	9
	1	Immediate Suuse (Final	and the second								Onset and D	Death
1		disease or condition resulting in death)	a.	a consequen		100					Bany	Δ
	L		5	epsi	S						3 044	1
Je.		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events conditions)										
Examiner	10	Cause (Disease or injury that initiated events resulting in death) Last	G. ————————————————————————————————————	iair							3 wee	125
		resulting in death) cast		a consequent								
edical			d	41061						<del></del>	-	
by Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	ath 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month		/ear
nysic		1 Yes 2 No 9 Unknown	9□ Unknown	t time or death	1 32	J Oliter (specify)						
V P	F	Part II. Other significant conditions	contributing to death b	out not resultin	ng in the u	nderlying cause g	iven in Part I.	23e. D	Oid toba	cco use contribute t	o the cause of d	eath?
								.   1	∏ Yes	2 <b>⊠</b> No 3 □ P	robably 4 🗍	Jnknown
Completed									Mas an	24b. Were a	utopsy findings completion of c	available ause of
E								F	enforme es 212	d?   death?	s 200 No	
Be	) ;	25. Was case referred to medical examiner?						eath (Check or	nly one)			
ုင	) ke	1 ☐ Yes 2 No	Hospital:		/Outpatier	11 3D DOX		7		ce 6 □Other (Spe	ecity)	
		27. Manner of Death  1 KNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	lry Year) 28	b. Time o Injury	W	ork?	28d. Descr	ibe how	injury occurred		
cati		2 Accident investigat 3 Suicide 6 Could no	be				]Yes 2 □No	204   2041	on /5***	et and Number or F	Pural Route Aliem	her
Certification:		4 Homicide determin	289. Place of In	jury - At home tc. (Specify)	, rarm, sti	reet, factory, office			r Town,		iurai Houle Num	
Medical			Physician: To the best aminer: On the basis of and manner st	of examination								3)
Me		29b. Signature and title of certifier		1		29c. Lice	nse number		290	d. Date signed (Mor	th, Day, Year)	
		1 Ham	W ICH	L.		D	32190		()	Tarch .	18 2	009
		30. Name and address of person wi	no completed cause of	death (Item 23	За) (Туре,	Print)						
		MONTGOMERY GEN				20832						
tate		31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	8	40						
strar		MAR 2 0 2	UUX June	w H	Spi	BASE!						
ev 1/2001					9		Comm.					

			State of Maryland State of Maryland		artment of H		nd Men	tal Hygien	4000	09002
	Dharaini		1. Decedent's Name (First, Middle, Last)					Date of Death Month D	ay Ye	3. Time of Death
	Physici /Medio		William Edward Smith				Ma	arch 9,	2008	5:14 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death		c. County of E	
			Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last	t hirthday)	Takoma I		Hrs or	Date of Birth	Montgo	mery Birthplace (State or Foreign
	Funeral Director		223–18–4265	Yrs.	Months Days		Min.	Month, Day, Yea	7)	Country) irginia
	ס		Usual Residence of Decedent							
	anylar show		10a. State 10b. County 10c. City, T							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Se-1:	octo	Maryland Prince George's Mt. 1	kaini					V	
	with the port	吉	10e. Street and Number 3326 Chauncey Street		10f. Zip Code 20712				itizen of Wha	it Country?
	leath	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13.1	Was Decedent of H	ispanic Origin	n? (Specify			American Indian,
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23e or 28e-1 show other traumatic event, it a Medical Evan ment from Item and the confilted at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 X Yes 2 ☐ No 1X Widowed 4 ☐ Divorced Year or Dates: WWII	l l	f Yes, specify Cuba 1 ☐ Yes 2 <mark>X</mark> No	ın, Mexican, I	Puèrto Rica	in, etc.)	C	White, etc. White
Ş	2 hou	ed	15. Decedent's Education	l6a. Decer	dent's Usual Occup	ation		16b.	Kind of Busin	
2	hin 73	ple	(Specify only highest grade completed)  Etementary/Secondary (0-12) College (1-4or 5+)	(Give life. l	kind of work done o DO NOT use retired	during most o d)	of working			
7	ed wit	Į O	12	Mail	Carrier					tal Service
Ē	be file tat Hy d oth	Be	17. Father's Name (First, Middle, Last)					rst, Middle, Maide		
3	ould Men Marke Matic	2	William Edward Smith  19a. Informant's Name/Relationship (Type, Print)	405 14-17	111			Carolin		
<u>a</u>	d 2 sl th and t7 ie r traur	3.3	112		ng Address <i>(Str</i> eet a Chillum l					
ē,	tem 2	100	20a. Method of Disposition 20b. Plac		sition (Name of natory or other place		Date	7		y or Town, State
Baltimore, Maryland 21215-0036	Pages ent of nt: if i		I Dullar 2 Michallation 3 Direlloval noth State		cConaty	1	4-3-08	3 Δ11	rora,	CO
<u>≡</u>	permit. Pages 1 and 2 Department of Health a importent: If item 27 is any injury or other tra 80 <u>09</u> 8.		21. Signature of Funeral Service Licensee	22	. Name and Addres	ss of Facility		, Au	I O Las	00
m	88 5 8	0	Dennis Otellian		cience Ca 9301 E.		ve.,	Aurora,	co 800	11
Г			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	ig, such as ca	ardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	H	GRAT PISE	26				Oliset and Death
	/Medical Examiner		Due to (or as a consequen	ice of):		•				
		e	Suentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
1	uted d ansit	min								
Ų,	an an rial-tr	Еха	resulting in death) Last Due to (or as a consequence of):							
8760,	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
9	ertifica ling pl	Med	tF FEMALE:		71				-	
Вох	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	eath 3	Ectopic pregnancy	,			23d. Date o Month	
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat 9 ☐ Unknown	n 5L	Other (specify)					
	that hed by deta	y Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.		23e. Did tobacci	o use contribu	ite to the cause of death?
rds	quires n sigr ald be							1 🗆 Yes	2□No 3[	Probably 4 X Unknown
000	aw require s been sig 2 should b	Completed						24a. Was an	24b. Wei	re autopsy findings available of to completion of cause of
Ä	The la	E						autopsy performed? 1 ☐ Yes 2 🔀 !	dea	th?  Yes 2 No
Division of Vital Records,	Physician: this certifica ral director, p	Bec	25. Was case referred to medical examiner?			26. Place o	of Death (Cl	heck only one)		
<u></u>	physic this co	2	1 ☐ Yes 2X No Hospital: 1 X Inpatient 2 ☐ ER			4   14015		5 Residence		(Specify)
U.S	ling F	lon	1 Natural 5 Pending (Month, Day Year)	Bb. Time of Intury	Wor	yat k? Yes 2 ∐ No		Describe how in	jury occurred	
<u>S</u>	Attending ir death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home	e. farm. str		163 2014		Location (Street	and Number (	or Rural Route Number,
<u>S</u>	after after Dire	Certification;	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	201, 120101), 011100			City or Town, Sta	ate)	
	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. [	Date signed (A	Month, Day, Year)
			Iny / Hother		48	183		Man	ch 12,	2008
	10		30. Name and address of person who completed cause of death (Item 2:	3a) (Type,		•		1		
	10		DR. IRVING V. WESTINGY		600 Carr	oll Av	e., T	akoma Pa	ark, MI	20012
	Sta Registi		31. Date filed (Month, Day, Year) 37 Registrar's Signatur	0	ule)					
	riegisti	ui	Du-11 to a see The see	6	7269					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 7:40 PM Saunders, Sr. 13 2008 Harrison March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1₩ 2□ F 9-6-47 Director 60 Virginia 219-52-5421 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21218 3609 Greenmount Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Myes 2 No If Yes, Give Year or DatesViet Nam 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗓 No specify: Black ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Medica once. (Give kind of work done during most of working life. DO NOT use retired) Raymond Metal Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Company 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Lillie Mae Johnson <u>John R. Saunders</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5268 Watt Abbey Road Appomattox, VA 24522 19a. Informant's Name/Relationship (Type. Print) John R. Saunders/Father Appomattox, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3/1<sup>D</sup>3<sup>t</sup>708 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Springfield Bapt. Church 4 ☐ Dopation 5 ☐ Other (Specify) Appomattox, VA 22. Name and Address of Facility 21. Signature of F neral Service Licenses ( E. B. Allen Funeral Home Hellmer 711 Griffin Blvd., Farmville, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Liver Physician several years Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unity Hig Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? /es 2 2 No certificate Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT 2438 946 March 13 2008 delam

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year)

Belinda Escanio

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Union Memorial

Sparle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March Geraldine E. Smith 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1+05 P1 BALTIMORE. ST. AG NES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 3, 1931 7. Age (In yrs. last birthday)
76 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 XF Director 212-28-6498 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland N/A 2500 Wilkens Ave. 10e. Street and Number 10g. Citizen of What Country? 2500 Wilkens Ave. 21223 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Sewing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymand M. Ensey Annie Smith ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 532 Catherine St. Baltimore, MD. 21223 19a. Informant's Name/Relationship (Type. Print) Bryan Smith, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Durial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill 03-19-08 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. Signature of Funeral Service Licensee 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 years Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the s should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1stemic 1erosis 3 Probably 4 □Unknown 2 No 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No has autonsy certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury completely filled in by the funeral 27. Manner of Death 1 X Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my spinion death. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19508 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

2016

CATONS AVE, Baltimore, MD 4229

900

Registrar's Signature

MASODD,

2008

AWAIS

31. Date filed (Month, Day, Year)

MAR 20

			For State of Marylan  1- State Registrar	-	artment of H rtificate of I			giene Reg. No. 🤈	000	00005		
	Physici	an	Decedent's Name (First, Middle, Last)     Howard W. Scott				2. Date of De Month	Day	Year	3. Time of Death		
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Dea	O3	13 4c. Co	2008 ounty of Death	11:20 A M		
	Funeral		Haven Nursing Home  5. Social Security Number 212-12-9334   1 🛭 M 2 🗆 F   7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Baltimore If Under 24 Hrs Hours Min		th ly, Year)	9. Birth	place (State or Foreign		
	Director		Usual Residence of Decedent				July 27,	1917		VA		
	arylan show ed at	'n	10a. State 10b. County 10c. Cit	y, Town or Lo						10d. Inside City Limits 1X\ Yes 2 \ No		
	the M	Director	MD 10e. Street and Number		Baltimore 10f. Zip Code	9		10g. Citizer	of What Cou			
	th with 23a or 1st be	al Di	2121 McCulloh Street		21217	7			JSA	,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⁄2 No	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No erto Rican, etc.)		Race - Americ Black, White, Decify: Black	etc.		
	72 hour natural lical Ex	ted b	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation	orkina		of Business/In			
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2	il Hygie other i	Be Co	17. Father's Name (First, Middle, Last)		рац	nter 18. Mother's Na	ame (First, Middle			y schools		
7	ould be Menta larked atic ev	To B	Benjamin Scott			Ellen Wright  (Street and Number or Rural Route Number, City or Town, State, Zip Code						
3	and 2 sh ealth and n 27 is rr ier traurr		19a. Informant's Name/Relationship (Type. Print)  Dwayne G. Scott / Son		ng Address (Street Brenbrook 1							
5	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Brurial 2 ☐ Cremation 3 ☐ Removal from State	lace of Dispo emetery, crer	sition (Name of matory or other place		Date		tion - City or T			
	nit. Pa artmen ortant: Injury		4 □ Donation 5 □ Other (Specify) Gar  21. Signature of Funeral Service Licensee		orest Vet. (			_	Mills, N	Maryland		
3	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee , 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217									
7,00,00	ticate be executed  /Medical bhysician and sthe burial-transit	edical Examiner	onset and Death  Due to (or as a consequence of):  b. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):									
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of dependent of the pregnant of the pregnant at time of dependent of the pregnant of the	ıl death 3 □	Ectopic pregnancy	/		230	d. Date of deliv	ery Day Year		
5 5 5 5	quires that en signed build be det	þ	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.			contribute to t	he cause of death? bably 4 Unknown		
	n: The law re ficate has bee r, page 2 sho	Completed			* P-5.		1□ Yes	psy ormed? 2 No	prior to co death?	opsy findings available empletion of cause of 2 ☐ No		
	ysiciai is certif directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3□ DOA Oth	er .	eath <i>Check onl</i> death <i>Check onl</i> death <i>Check onl</i> death		Other (Speci	fv)		
	nding Ph th. : After th s funeral	tion: T	27. Manner of Death 1	28b. Time of Injury	Wor		28d. Describe					
	To the Hospital or Attending Physician: The law within 24 buturs after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At h building, etc. (Specification of the suit	ome, farm, str	reet, factory, office		28f. Location ( City or To	Street and f wn, State)	Number or Rur	al Route Number,		
	he Hospi in 24 hour he Funer bletely filli	Medical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examinar and manner stated.	wledge, death	h occurred at the tire to the	me, date and place opinion, death oc	ce, and due to the curred at the time	cause(s) ar date and p	nd manner as s ace, and due	stated. to the cause(s)		
	To the To the Comp	ž	29b. Signature and title of certifier		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)		
			30. Name and address of person who completed cause of death (Iten	23a) /Type	Print)	001042	67	E	5-17-08	5		
	5		Dy Vacon Committee	daen	827	Linde	n Hr.	Baltro	ui ie	40.21201		
	Sta Registr		31. Date filed (Month Pay, Year) 2008 32. Registrar's Signa	and the	parte					ė.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 8:25 Irene Catherine Stranges 19 March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Blakehurst Baltimore Towson 8. Date of Birth (Month, Day, Year)
Sept. 28,1920 Birthplace (State or Foreign Country)
 New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F 083-12-6066 87 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 👿 No Baltimore Maryland Towson Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 1055 W. Joppa Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: white þ 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Gaska Catherine Gedaika 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau Lynn Slawson/daughter 7401 Knollwood Rd. Baltimore, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Green Mount Crematory Mar. 20,2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 4500 York Rd baltimore, MD 21212 21. Signature of Funeral Service Licenses 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ~ 3 years **Physician** zeemero /Medical Due to (or as onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undern in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and to for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnat 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an autopsy perform 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☑ No 2 ER/Outpatient 3□ DOA ၉ 1 Inpatient funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manne@stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

Stat

Registrar MAR 2 0 2008

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23)

Year)



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Certificate of Death	Reg. No/2 0 0 0 0 0 0 7						
	Physicia		1. Degedent's Name (First, Middle, Last)  Marvin Salmond		2. Date of Death Month Day Year Year 1:45 MM						
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 8322 Tacobs Road West	4b. City, Town, or Location of Death Sever $\land$	4c. County of Death  Anne Arundel						
	Funeral Director		5. Social Security Number 3. Social Security Number 13.53 6. Sex 13. M $_2\square$ F 7. Age (In yrs. In $_3\square$ F 4.4	ast birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)						
	/aryland f show ed at	ō	ALD A A	r, Town or Location	10d. Inside City Limits 1 <b>p√</b> es 2  □No						
	with the A 3a or 28a- st be notifi	Funeral Director	10e. Street and Number 8322 Tach & Road West	10f. Zip Code 21144	10g. Citizen of What Country?						
98	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y Funera	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give	S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Dictan, etc.)  14. Race - American Indian, Black, White, etc.  Specify:						
15-0036	n 72 hours 1 "natural", ledical Exa	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work  The DQ NOT use retired)	ting 16b And of Business/Industry						
d 2121	filed within I Hygiene. other than " ent, the Mer		Elementary/Secondary (0-12)  Colege (1-4or 5+)  17. Eather's Name (First Middle, Last)	Entrepreneur 18. Mother's Narm	e (First, Middle, Maiden Surname)						
Maryland	should be and Mental s marked o umatic eve	To Be	James Thomas Salmond,	Se.   Mar							
	and 2 sh lealth and m 27 Is m		Ina Keva Salmond (Wife)	8322 Jacobs Road U							
Baltimore,	Page nent o ant: If any or		4 Donation 5 Other (Specify)	emetery, crematory or other place)	22.08 Baltimore, mo						
Ball	permit. Departr Importa any inji	21. Signetur of Funeral Service Licensee, 2 Varie and Address of law tene Funeral Services Vaugna C. Steene 5151 Batto. Nat'l Pile (21229)									
	Physician		23a. Part1. Enter the disease, or complications that caused the death shock, or heartfailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	n. Do not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between Onset and Death  Lea-S						
1	/Medical Examiner		Due to (or as a consequ	ience of):							
April	unsit A de	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Jence of):							
68760,	death certificate be executed e attending physician and d for use as the burial-transit		resulting in death) Last  C. Due to (or as a consequence of the conseq	uence of):							
_	± 50 €	/Medical	IF FEMALE: 23c. If yes, outcome pf pregna	prov	and Date of Alliana						
P.O. Box	w requires that the death ce been signed by the attendir should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	l death 3 □Ectopic pregnancy	23d. Date of delivery  Month Day Year						
	requires that the een signed by the rould be detache	by	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 → 0 3 ☐ Probably 4 ☐ Unknown						
Division or Vital Records,	The law rei	Completed			24a. Was an autopsy performed?  1						
Vital	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Othor	th (Check only one)						
100	ding Physician: The lav n. After this certificate has funeral director, page 2	n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 □ DOA	ome Residence 6 □Other (Specify)  28d. Describe how injury occurred						
visior	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
٥	spital or ours afte leral Dir filled in	I Cert		wledge, death occurred at the time, date and place							
	the Hosin 24 h	Medical	(Check only 2 Medical Examiner: On the basis of examina one) and manner stated.	tion and/or investigation, in my opinion, death occu	arred at the time, date and place, and due to the cause(s)						
	Voith To 1	Σ	29b. Signature and title of certifier  Mo Albert	29c. License number 0.65.776	29d. Date signed (Month, Day, Year)  March 19.2008						
	Y		30. Name and address of person who completed cause of death (Item	123a) (Type, Print)  OD Charter Drive Sto :	200 Columbia MO						
	Sta Regist		31. Date filed (Month, Day, Year)  32. degistrar's Signa  MAR 2, 0, 2008	ture Sparle	29d. Date signed (Month, Day, Year) March 19, 2008 200 Columbia, MO						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day March 10, 7:36 PM M Dorothy Elizabeth Shackelford 2008 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Prince George's Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Months Days Hours 1 □ M 2 👽 F Jan 9, 577 24 0458 86 1922 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 □Yes 2 □ No Director Maryland | Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19706 Kildonan Drive 20879 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Š White 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Adm. Assistant NASA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Henry Gerhardt Goldie La'Fever 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew T. Richards (Grandson) 19706 Kildonan Drive, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) March 17, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Memorial Gardens Waldorf, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signatur Funeral Service Licenses Yours Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23ar Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Obstruction Amall bowl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 At started Completed Be Certification: To

/Medical Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician þ After this 24 hours a within 24 hor To the Fune

Examiner thours after death.

uneral Director: A
ely filled in by the for

Physician

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

"natural",

7 is marked other than "natu traumatic event, the Medical

permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra: once.

**Physician** 

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

I.	Jenn 10 07 /10 cm	coming 17pe	1 Li Yes 2 Prodadiy 4 Unknown					
	_				24a. Was an autopsy performed?  1			
	Was case referred to medical			ath (Check only one)				
	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3 D	Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Dea 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
	determined		ome, farm, street, factor	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29					e, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)			

29c. License number

D0055120

29d. Date signed (Month, Day, Year)

March 11 zor 8

State Registrar

Medical

29b. Signature and title of certifig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Sonthern almen MD 31. Date filed (Month, Day, Year) MAR 2 0 2008

avenue St dut 310 Was langton DE 20032

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** March 15, Kathleen C. Taylor 9:27 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 96 063 20 9566 Director <u>October 7, 1911 West Virginia</u> Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11324 Marlee Ave 20735 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo ģ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Real Estate 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Real Estate Federal Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Cain Anna Connolly ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. William Taylor (Son) 11324 Marlee Ave P.O. BOx 557, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery March 25, 2008 Clinton, MD ral Se lice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 10139 Alexandria Ferry Road, Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to or as a consequence f): /Medical Examiner Due to lor as a nse luence of): Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine aftending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🛛 No Abril 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 X Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) anne 30. Nave and address of person who completed cause of death (Item 23a) (Type, Print) Upper Marlboro, Marylad 20 172 Penn. Ave #18 MUCION egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-f per inf e8784-21-08 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Joseph Tippett March 16, 2008 1:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** XX M 2□ F Months Days Washington DC Director Feb 21, 1936 579 46 8366 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10h. County Clinton an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Maryland PG Yes 2X No Director Washington 10e. Street and Number 8106 Woodyard Road POB37 10f. Zip Code 20735 10g. Citizen of What Country? 2 should be filed within 72 hours after death with t and Mental Hygiene.

is marked other than "natural" or items 23a or 2 20010 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify:White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) å Mechanic other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN Joseph Tippett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar important: If item 27 is any Injury or other trau Joseph Tippett (SON) 3556 B 13 St. NW, Washington, DC 20010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ★★ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory March 18,2 008 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d K Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a conservence of): /Medical Examiner Malmuticles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed

1 Yes 2 No After this certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၀ 1 🔣 Inpatient 2 ER/Outpatient 3□ DOA 27. Manyler of Death 1 ☑ Natural Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: qth, Day Year) Injury 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 2 Medical Examin 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28639 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7501 Surra Registrar's Signature Jacques Zephirin, 31. Date filed (Month, Day, Year) MAR 2 0 2008 MD Surratts Road #303, Clinton, MD 20735 State Registrar

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of

31. Date filed (Month

GBME

eath (Item 23a) (Type, Print)

6701

32. Registrar's Signature

N. amles St. Bults. Md Zizax

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 11, Day 2008 **Physician** Richard Wright 11:13 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 153M 2□ F 64 Director 2-12-44 Virginia 226-64-0755 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 TYes 2 No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1425 Winchester Street 21217 by Funeral USA Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23 ury or other traumatic event, the Medical Exterminer must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 257 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Anderson Wright ပ Geneva Nowlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garvan Hayes / Wife 1425 Winchester Street, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any injury or ot Springfield Baptist Church Cemetery 1 → Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-17-08 Appomattox County, VA 21. Signature 22. Name and Address of Facility Bland-Reid Funeral Home Funeral Service Lic PO Box 325, Farmville, VA 23a. P. (1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final CANCER COLON Physician MONTHS sease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s autopsy performe 2**X** No or Attending Physician: director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Leath 28a. Date of Injury 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death. To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64395 MARCH 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MD 6565 NEHARLES ST, SUITE 209 BALTIMORE, MD 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-01996 Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

09013 2008

aurice vvaiker		For State  Certificate of Death  Reg. No.								
Physician		egistrar  2. Date of Death Decedent's Name (First, Middle,Last)  3. Time of Death Month Day Year 1035 hrs								
ledical Examin		Maurice Walker March 11, 2008 March 12, 2008								
	4	a. Facility Name (if not institution, give street and number)								
		2215 ASHIOTI Street								
Funeral		Months Days Hours Min.								
Director		217-80-7002 13M 2F 49 Yrs. World 3/13/1958 New York								
8	_	Journal Residence of Decedent  10d. Inside City Limits 10d. State 10b. County 10c. City, Town or Location								
w any	] '	MD Baltimore								
Aaryland 28a-f show 3 at once.	희	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								
e Mar or 28a	Director	2215 Ashton St 21223 USA								
ith the 23a c		ASTROM Developes a last to the West Service List Mass December of Hispanic Origin? (Specify Yes or No-								
ath w items	= 1	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								
er de		3 Widowed 4 Divorced If Yee, Give Year 1 Yes 2 X No specify: Specify: Black								
15-0036 filed within 72 hours after death with the Maryland I Hygiene. ed other than "naturat", or items 23a or 28a-f sh t, the Medical Examiner must be notified at once	g-	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)								
5-0036 ed within 7/ tygiene. other than	립	10th Certified Auto Mechanic Auto Repair  18. Mother's Name (First, Middle, Maiden Surname)								
Hygic d othe		17. Father's Name (First, Middle, Last)								
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	B	Mack Thomas    Della Savage								
	۴	Chandra Walker Wife 810 Abbott ct Baltimore MD 21202								
imore, MD 2 Pages 1 and 2 shoul nent of Health and Nant: If item 27 is no or other traumatic	-	20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State								
Ore ges 1: rof H ther if it		1 X Burial 2 Cremation 3 Removal from State Mt Zion 3/18/2008 Lansdown, MD								
Baltimore, permit. Pages 1 a Department of He Important: If ite	-	4 Donation 5 Other Specify:								
Baltimore, MD permit. Pages I and 2 shu Department of Health and Important: If item 27 is injury or other traumat	- 1	21. Signature of Funeral Service Licensee  W. Wesley Chavis III Funeral Service P.A.  10.684 Southern MD BLVD Dunkirk, MD 2975.4								
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart siture. List only one cause on each line.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart between Onset and Death Death								
/Viedical		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease								
\ aminer		or condition resulting in death)  Due to (or as a consequence of):								
		sequentially list conditions, any leading to immediate  Due to (or as a consequence of):								
	j.									
×- =	Examine	cause. Enter Originary that initiated events resulting in death) Last Use to (or as a consequence of):								
Records, P.O. Box 68760,  The law requires that the death certificate be executed care has been signed by the attending physician and page 2 should be detached for use as the burial - transit	al E	d								
O, : be ex sician	Medical	WINDED  AMENDED 23a, 27 per me g877 3-21-08 vt  15 FEMALE:  23d. Date of delivery								
376 ificate ig phy s the t	n/M	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year								
x 61 h cert tendir use a	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)								
Bo e deat the at	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?								
Division of Vital Records, P.O. talor Attending Physician: The law requires that the rastler death.  The Albert his certificate has been signed by the funeral director, page 2 should be detach led in by the funeral director, page 2 should be detach	by P	1 Yes 2 No 3 Probably 4 Vunknown								
S, F puires an sign ald be		24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of								
ord aw rec as bee	를	autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No								
Zec The L	Completed	OC Please of Peath (Check only one)								
	m	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; 4 Nursing Home 5 Residence 6 Other: Scene								
FV; Physi er this	₽	1 Vives 2 No les ribe bow injury occurred								
n O ding ding h. After fune	Ë	1 X Natural 5 Pending (Month, Day, Tear)								
SiO Atten r deat ector by the	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City								
Division of Vital Rec pital or Attending Physician: The ours after death. eral Director: After this certificate I filled in by the funeral director, page	Certification:	determined (Specify)								
F 2 2 E		29a Certifier . The last of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To the Hos within 24 h To the Fun completely	Medical	293. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
F % F 8	≗									
N.		Theodor W King The March 12, 2008								
A BA	1	7 Name and address of person who completed cause if death (Item 281)  Theodore M. King, Ir. MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
11) 13		Theodore W. King, G., W.E.								
	State									
Regi		ODICINAL								
DHMH 17 Rev 1	/2001	OMONAL								

# David Wyatt

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 73 **Physician** David W. Wyatt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Year If Under 24 Hrs. Good Samaritan Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 21, 19 Birthplace (State or Fo Country) unk **Funeral** 1 X M 2 □ F 64 July 1943 Director 215-40-4371 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County must be notified at 1√ Yes 2 No MD Baltimore Director 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or 6116 Belair Road 21206 Funeral <u>USA</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 XNever Married 2 Married 0. 1 ☐ Yes 2 No ģ Specify: black 3 ☐ Widowed 4 ☐ Divorced d other than "natural", event, the Medical Exa Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be Pages 1 and 2 should ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troones. Good Samritan Hospital 6501 Loch Raven Blvd Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MA **Physician** /Medical Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examine The law requires that the death certificate be executed van physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗌 No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy perform certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 1 TYes 12 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral d 27. Manner of a eath 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signature and title of certifier 29c/ License number 29d. Date signed (Mopth, Day, Year) Name and address of person who completed cause of death (It on 23a) (Type, Print) ansua4 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
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2008

		•	, 101	epartment of Health and Mer Certificate of Death		ne. 008	09015				
	Physici	an	Decedent's Name (First, Middle, Last)	2.	Date of Death Month	Day Year	3. Time of Death				
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4h Ch T	march !	4c. County of Death	11:40>M				
	Examin	er	Mining side Those & Say - 749	4b. City, Town, or Location of Death		Balt	mue				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year   If Under 24 Hrs. 8.	Date of Birth	9. Birth	place (State or Foreign				
	Director		212–03–7417	rs. Months Days Hours Min.	1–16–19		ryland				
	and wo		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location			10d. tnside City Limits				
	Maryl -f sho	tor	Maryland Baltimore	Parkville			1 ☐ Yes 🍇 No				
	th the	irec	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	ntry?				
	ath wi	ral	8800 Old Harford Road	21234		US					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show appring or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes ★★ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rice 1 ☐ Yes XXX No Specify:	y Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: V					
Ö	2 hou	ted	15. Decedent's Education 16a, D	Decedent's Usual Occupation	161	b. Kind of Business/Ir	dustry				
21215-0036	within 7 iene. r than "r	Completed	Elementary/Secondary (0-12)   Coltege (1-4or 5+)   _	Give kind of work done during most of working ife. DO NOT use retired)  Aper carrier		ews Americ ewspaper	can				
5	e filed al Hyg I othel vant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F							
ylaı	should be and Mental s marked o	To	(unknown) Wipfield	Eliza	beth Bo	oker					
Maryland	12 sh h and 7 is m traum	7 8		Mailing Address (Street and Number or Rural Re							
	1 and Health tam 27 other tr		20a. Method of Disposition 20b. Place of D	04 Orchard Lakes Drive Disposition (Name of Date		win, Mary] c. Location - City or T					
altimore,	Pages nent of I int: If itu		TX District 2   Uramation 3   Hamoval from State   *	chedral Cemetery 3/25/		altimore,					
Balti	permit. Departm Imports any inju		21. Sign tur of Funeral Service Licensee  22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211								
	- ·		23a. Fart 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or re	spiratory arrest	Maryland	Approximate Interval Between				
	Pnysician	66	Immediate Cause (Final disease or condition				Onset and Death				
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)	):							
ķ.		5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	):							
	uted d ansit	Examiner	cause. Enter Underlying Cause Unsees 3 in july that initiated events c.								
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8760,	icate be executed physician and s the burial-transit	lcal									
9	ding p	/Med	IF FEMALE: 330 It was outcome of programmy								
Вох	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  23c. It yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year				
P.O.	at the c by the tacher	hys	9 □Unknown 9□Unknown								
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ord	requi	eted	M-2010				pably 4				
Sec	has t ge 2 s	Completed	hypothypoid		24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of				
Division of Vital Records,		e Co	C +	26. Place of Death (C	1  Yes 2		2 No				
$\equiv$	ysicia is cert direct	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outp	Other		e 6 Other (Speci	W Assolul Cive				
0 0	or Att. nding Physician: after de ath. Director: After this certifica in by the funeral director, i		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Intit		. Describe how	injury occurred					
S	tending teath. tor: After the funer	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No							
	I or Attendation after death Director:	Certification:	4 Homicide determined 28e. Place of Injury - At home, tarm building, etc. (Specify)	n, street, tactory, office 28t.	City or Town, S	et and Number or Rur State)	al Houte Number,				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 €ertifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and	due to the caus	se(s) and manner as s	stated.				
	n 24 h	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/and manner stated.								
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month,	Day, Year)				
•	1		I hay kley no	V31295		3/19/08					
	14		30. Name and address of person who completed cause of death (Item 23a) (To Wend ) (Cops ( O To I M Charles S	1 57 1/2 7	Ma	1 2,25	/				
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature	1 A.			/				
	Registr		31. Date filed (Month, Day, Year)  MAR 2 0 2008	parti.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 9877 3-20-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death MARCH **Physician** Day Year 9,53PM WYCHE WILLIAM 2008 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22 Athol St. NIA Himore Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 213-28-0613 1 M 2 □ F 76 Hours MD **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. Cify, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Markea Examiner must be notified at once. MD NIA Baltimore 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Walnut Avenue 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Black þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tostal service Mail Handler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nannie Wyche Barry Wylie ဥ 19a. Informant's Name/Relationship (Type. Print), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Walnut Baltimore, MD. 21229 Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mulls Carrison 3.2408 Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility erre Funeral Services Pike Balto. Hd. 21229 5151 Baltimore Wat'L 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACINETOBAC **Physician** PNEU MO NIA disease or condition resulting in death) ONE AND A /Medical Due to (or as a consequence of): WITH HALF MONTHS. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CO PD 23e. Did tobacco use contribute to the cause of death? Completed by WITH NEUROPATHY 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CERVICAL STE NO SIS ESSENTIAL PERTENSIOND Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0018362 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Future Care Koma K. Dang 31. Date filed (Month, Day, Year) Baltimore State MAR 2 0 Registrar 2008 DHMH 17 Rev 1/2001

Records, P.O. Box 68760 LAWRENCE Division or Vital

The law requires that the death certificate be executed

attending physician and for use as the burial-transit ned by the a s certificate has birector, page 2 s this funeral After: filled in by the within 24 hours a

To the Funeral I

completely filled

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

er than "natur , the Medical B

permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If item 27 is marked ott any Injury or other traumatic ever ance.

Physician

Examiner

/Medical

Director

Completed by Funeral

Be

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Completed by Physician/Medical Exami

Be

Medical Certification: To

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical examiner? 27. Manner of Death 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VISHNU DEEPIKA EVURI, 900 SOUTH CATON AVE., BALTIMORE, MD - 21229

P 20998

MARCH 16, 2008

State Registrar

31. Date filed (Month, Day, Year) MAR 2 0 2008

E. Cishnu Decpika



MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Lindamarie Abbamonte 12:15 p March 3, 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death S 15311 Beaverbrook Silver mom Cour 0m0-16 313 If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Aug • 18, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) , <sup>Year)</sup> 1948 Days Hours 218-52-9707 1 □ M 2 🖫 F 59Yrs. Washington, DC Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15311 Beaverbrook Court, Apt. #3B 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Silvio G. Abbamonte Gertrude M. Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Abbamonte/Brother 18531 Breathedsville Road, Boonsboro, MD 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) March 20c. Location - City or Town, State 20a. Method of Disposition 5, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Mary 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of); Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 ☑ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown the cause of death? 4 Onknown bably opsy findings available empletion of cause of 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29b.

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner more.

Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician the attending

burial-tra the After this certificate has been signed by funeral director, page 2 should be detact within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Part II. Other significant conditions	contributing to death but not re-	23e. Did tobacco use contribute to the cause of death			
	<u>-</u>			24a. Was an autopsy performed?  1  Yes 2  1 Yes 2  No	
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3 □ D	Home 5 Desidence 6 □Other (Specify)		
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not I determined		forme, farm, street, factor	28f. Location (Street and Number or Rural Route Number City or Town, State)		
29a. Certifier 1 Certifying P	hysician: To the best of my kn miner: On the basis of examin	owledge, death occurred ation and/or investigatio	d at the time, date and plac n, in my opinion, death occ	e, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)	

State Registrar

31. Date filed (Month, Day, Year)

nature and title of etifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mooms Silver 32 egistrar's Signature

1 MO OMF

29c. License number

2101

29d. Date signed (Month, Day, Year)

2008

**ORIGINAL** 

DHMR 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician Month Chester Lynn ALBRIGHT Jr. March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, You Aug. 14, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1⊠M 2□F 214-34-9826 70 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11007 Rosewood Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 □ No If Yes, Give Year or Dates: 1962–65 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 28 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. Specify white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) driver bread company 11 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Lynn Albright Sr. Helen Rubeck or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Janet Albright -wife 11007 Rosewood Drive, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 StBurial 2 □ Cremation 3 □ Removal from State Injury o Rest Haven Cemetery 3/12/08 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco-use contribute to the cause of death? by hronic 1 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performe certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 CR/Outpatient 3 □ DOA 은 27. Manne f Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No ieral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29b. Signature and title of certifier

SH-4+1

State Registrar

DHMH 17 Rev 1/2001

Registrar

. Hagerstown

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 4,2008 Year **Physician** C. Botta 12:50a M Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #828 Chevy Chase Montgomery 4701 Willard Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 5, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 291-18-0507 Director 86 Ohĩo Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic everal. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Montgomery Chevy Chase MD ¥∏Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20815 4701 Willard Avenue #828 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. ģ Specify: 3₺Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angelina Baraona Mauro Giaimo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5908 Springfield Drive Bethesda, Md. 20816 19a. Informant's Name/Relationship (Type. Print) Mary B.Coffman/Daughter 20c. Location - City or Town, StateOhio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State All Saints Cem. 3/08/2008 Northfield Center, 4 Donation 5 Other (Spenty) PANTE TO ANDESS RINGLDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 XUUXX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute respiratory failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End stage chronic obstructive lung disease S. Lentielly let can illims if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the attending physician and the for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death signed by the at d be detached for 5 ☐ Other (specify) 1□Yes 2又No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Situs Inversus 1 Yes % No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sta 29b. Signatur nd, title of certifie 29d. Date signed (Month, Day, Year) MD1924 March 4,2008 dress of person who completed cause of death (ftem 23a) (Type, Print) 5530 Wisconsin Avenue #800 Chevy Chase, Md20815 Steven M.D. Lerner

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2008

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Alice E. Boston -ebruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner BWMC** Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OCT 18 9. Birthplace (State or Foreign 5. Social Security Number 7 Age (In vrs last hirthday) 6. Sex **Funeral** Days Min. Year 914 1 □ M 2√□ F Maryland 93 Yrs. 213-12-7987 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Maryland Anne Arundel Gambrills 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturai", or items 23a or edicai Examiner must be 2530 Brickhead Rd. 21054 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 💥 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 ☐ Divorced the Medicai 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) 2yrs Nurse Cooney Agency Pages 1 and 2 should be filed w finent of Health and Mental Hygie tant: If item 27 is marked other to jury or other traumatic event, th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas T. Ridgley Mary Frances Queen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Ridgley(Brother) 2542 Brickhead Rd. Gambrills, Md. 21054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or Memorial Park 3-4-08 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Williame Resease of Eacilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

AVINAVY AVEVY DISEASE 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner SUZLES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 V No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 █ No Certification: To 2 ER/Outpatient 3 DOA 27. Many r of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely within 2 29d. Date signed (Month, Day, Year) Wich M MD.

State Registrar 31. Date filed (Month, Day, Year)

Jeorge

MAR 0 5 2008

Solution of the second of the



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSP-tel Drive, Clen Burnie, MD 21/61

DHMH 17 Fev 1/2001

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	Baltimore, Maryland 21215-0036
Ph	permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar
ys	Department of Health and Mental Hygiene.
sic	Important; If item 27 is marked other than "natural", or items 23a or 28a-f sh
ia	any injury or other traumatic event, the Medical Examiner must be notified
ı	0000

Division or Vital Records, P.O. Box 68760,

Director  Direct	In the second se									
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Wonths Days Hours Min. 12/10/1962 M. Usual Residence of Decement	Birthplace (State or Foreign Country)  aryland  10d. Inside City Limits  1X Yes 2 No  at Country?  American Indian, White, etc.  lack  lack  less/Industry  Brown									
Funeral  5. Social Security Number  6. Sex 1. Mage (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   12 / 10 / 19 62   Mage   12 / 10 / 19 / 10 / 19 / 10 / 10 / 10 / 10	Birthplace (State or Foreign Country)  aryland  10d. Inside City Limits  1X Yes 2 No  at Country?  American Indian, White, etc.  lack  lack  less/Industry  Brown									
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Usual Residence of Decedent	10d. Inside City Limits  1 ★ Yes 2 □ No  at Country?  American Indian, White, etc.  lack hess/Industry  Brown									
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Maryland Prince Georges    Aquasco   10e. Street and Number   10f. Zip Code   10g. Citizen of What   10e. Street and Number   10e. Street and Numb	American Indian, White, etc. lack less/Industry									
10e. Street and Number   10g. Citizen of What   10g. Citizen of Wh	American Indian, White, etc. lack less/Industry  Brown									
23411 Daniel Payne Street    1. Marital Status	White, etc.  lack  less/Industry  g  Brown									
12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specity Yes or No-Rican, Puerto Rican, etc.)   14. Race-Black, varied Forces?   1   Yes   2   No Specify:   1   Yes   2   No S	White, etc.  lack  less/Industry  g  Brown									
Armed Forces?  1 Mover Married 2 Married 1 Married 3 Married 5 Mar	lack  ess/Industry  ag  Brown									
Specify B   Spec	ag Brown									
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Busin (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State and Number of Rural Route Number, City or Town, Sta	Brown									
(Specify only highest grade completed)  (Specify only highest grade completed)  (Specify only highest grade completed)  (Sive kind of work done during most of working life. DO NOT use retired)  Machine Operator  Mail Ba  18. Mother's Name (First, Middle, Maiden Surname)  John Wesley  19a. Informant's Name/Relationship (Type. Print)  Mary Brown / Wife  20a. Method of Disposition  (Sive kind of work done during most of working life. DO NOT use retired)  Machine Operator  Mail Ba  18. Mother's Name (First, Middle, Maiden Surname)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State and Number of Rural Route	Brown									
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John Wesley Brown Mary R.  19a. Informant's Name/Relationship (Type. Print)  Mary Brown / Wife 23411 Daniel Payne St. Aquasco, Mary Brown / Date 20a. Method of Disposition (Name of Date 20a. Method of Disposition)										
Wesley  John Wesley  John Wesley  John Mary  R.  19a. Informant's Name/Relationship (Type. Print)  Mary Brown / Wife  John Mailing Address (Street and Number or Rural Route Number, City or Town, State and Street and Number of Rural Route Number, City or Town, State and Number of Rural Route Number of Rural Route Numb										
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The second process and the second process are second process.										
1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)	y or Town, State									
4 Donation 5 Other (Specify) St. Phillips 3/08/2008 Aquasco	,Maryland									
21. Signature of Puneral Service Licensee 22. Name and Address of Facility Adams Funeral Ho										
191 20605 Aquasco Rd. Aquasco, Mary										
23a. Part1. Ent., the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between									
/Medical disease or condition resulting in death)  Jue to (or as a consequence of):	chan									
- vaminer										
Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):									
Due to (or as a consequence of):    Constitution	ause (Disease or injury									
that initiated events resulting in death) Last Due to (or as a consequence of):	hat initiated events c									
C. Due to (or as a consequence of):    Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting										
No. if yes, outcome pf pregnancy  23d. Date of	23d. Date of delivery  Month Day Year									
23b. Was decedent pregnant in the past 12 months?										
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   23d. If yes, outcome pf pregnancy   23d. Date or Month   23d. Date or Mon	,									
	te to the cause of death?  ☐ Probably 4 ☐Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Yes 2   Yes 3   Yes 2   Yes 3   Yes 3   Yes 3   Yes 3   Yes 3   Yes 4	Probably 4 Unknown									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Mildred Blanks March 8. 2008 1:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien of Mt. Airy Mt. Airy Carrol1 Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 1 □ M 2 🗓 F Director 191-18-8556 May 10,1923 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Director Maryland | Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or USA
14. Race - American Indian, 713 Midway Avenue Apt. #211 21771 Funeral "natural", or items Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify. Specify: White Completed by 3 ₩idowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be В. Pages 1 and 2 should ပ Harry Martin Lillian Krueger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other trains Janet Blanks-Peyser/Daughter 1780 Pine Knob Road, Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/13/2008 Greenwood Cemeterv Lancaster, PA 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Serv 23a. Part. One whe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page periormed? 1∐ Yes 2 → Ho Monboer RHODENIA 21 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to edical examiner? director Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 2 who completed cause of dear

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

or Vital

Division

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

burial-trar as detached for should be has page 2 To the Hospital or Attending Physician: completely filled in by the funeral director, this death. after death 24 hours a within 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

traumatic event,

other

5

is marked

nt of Health a: If item 27 is

permit. Page Department o Important: If any injury or

**Physician** /Medical

with the

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

Registrar

Director 10e. Street and Number by Funeral 11. Marital Status 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced Be Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 23a. Part Enter the disease, or complications that caused me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1 Matural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 덛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A50689 031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILE MOTA A 7 OW. MD. 20731 CRINTER 7503 SURRATTI RD CLINTUNMO TATIGOON GARAY MARA NATHTYOS 31. Date filed (Month, Day, Year) MAR 0 5 State 2008

DHMH 17 Rev 1/2001

08-01792 Isidro Correa

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

	1- For State Certificate of Death Registrar	1	Reg. No.					
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Ye	3. Time of Death ar 0920 hrs				
Trical Examine		own, or Location of Death	March 3, 2008					
	5813 Oland Drive Hyatts			George's				
Funeral			8. Date of Birth (MM/DD/YYY)	y) 9. Birthplace (State or Foreign				
Director	216-19-7133 <sub>1</sub> X <sub>M 2</sub> F 53 <sub>Yrs.</sub> Months	B Days Hours Min.	5/19/1954	Country Mexico				
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
<b>*</b>	MD   Prince George   New Carrollt	on		1 Yes 2 No				
the Maryland t or 28a-f show tified at once. Director	10e. Street and Number 10f. Zip		10g. Citizen of W					
ith the Maryland 23a or 28a-f sho notified at once		)784	Mexic					
be ms	11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent If Yes, specific Ye	nt of Hispanic Origin? ( Spec y Cuban, Mexican, Puerto Ric		e - American Indian, Black, ite, etc.				
hours after death "natural", or ite Examiner must ted by Fun	1 3 Widowed A Divorced III tes. Give tear	Mexican No specify:	Specify:	White				
ours aft atural" xamine		Occupation (Give kind of working life, DO NOT use retired		Business/Industry				
within 72 hour within 72 hour giene. her than "natu Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)  Labore			truction				
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than c event, the Medical	17. Father's Name (First, Middle, Last)	18.Mother's Name (F	irst, Middle, Maiden Surnam	e)				
215 be file mtal H rrked cent, th	Isidro Correa		Cardoza					
D 21 should and Me 7 is ma		,	ral Route Number, City or To					
and 2 sho lealth and tem 27 is traumat	20a Method of Disposition 20b. Place of Disposition (Nar	ne of cemetery,	Date 20c. Location	on , Md , 20784				
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other traumatic event, the Med injury or other traumatic event, the Med To Be Comi	1 Burial 2 Cremation 3 Removal from State Panteon San 4 Donation 5 Other Specify:	Lorenzo	9/2000 Mex Mex	ico City,				
altir mit. P partme portar	4 Donation 5 Other Specific Tesonco 21. Siz attre of Funeral Service icense, 23 Name and	Address of FiguraLDI	FUNERAL SE	RVICE, P.A. Spring, Md20910				
	23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode	Columbia bl	vd.Silver S	pring, Md20910				
Physician 'Medical	failure. List only one cause on each line.	or dying, such as cardiac or n	espiratory arrest, shock, or m	Between Onset and Death				
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Neck Injury  Due to (or as a consequence of):							
	Sequentially list conditions,  if any, leading to immediate  Due to (or as a consequence of):							
nin	If any, leading to immediate Due to (or as a consequence of):  Cusese. Enter Underlying Cause (Disease or injury that initiated							
ted nisit	events resulting in death) Last  Due to (or as a consequence of):							
760, icate be executed physician and the burial - transit	unpended Amended							
760, icate be execut physician and the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date					
Ox 687 ath certifi	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe	3 Ectopic pregnanc	cy Month	Day Year				
). Box 687 the death certification by the attending collection is as the physician of physician of the physician of the collection of the	1 Yes 2 No 9 Unknown 9 Unknown							
ed by letach		g cause given in Part I.		ntribute to the cause of death?  3 Probably 4 Unknown				
ords, Pw requires to we requires to seen sign should be contacted.		_	Approximation and approximation of the process.	. Were autopsy findings available				
of Vital Records, I g Physician: The law requires ther this certificate has been sig meral director, page 2 should be			autopsy performed?	prior to completion of cause of death?  1 ✓ Yes 2 No				
an: The criticate tor, pag		26.Place of Death (Check or	1 Yes 2 No	1 Yes 2 No				
F Vita Physicia rr this cer ral direct	examiner?	OOA Other Nursing	Home 5 Residence 6	✓ Other: Scene				
on of Vital I ending Physician: sath. or: After this certifi the funeral director, thing. To Be of			28d. Describe how injury occu all	urred				
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Di Hospital 24 hours a Funeral 1 stely filled		e time, date and place, and d	lue to the cause(s) and mann	ner as stated.				
To the within To the comple	Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.							
1 2	29b. Signature and title of certifier	c. License number  O.C.M.E.	March 4,	gned (Month, Day, Year) 2008				
•	30. Name and address of person who completed cause of death (Item 23a)							
		et, Baltimore, MD 212	201					
Stat	ae 31. Date filed (Month, Day, Year) 6 2008 32. Fedistrar's Signature	)						

Compared to Present Properties				For State Registrar		State of Ma		partment of H e <i>rtificate of L</i>		, 0	iene eg. No. 2	ΠR	0002	7	
### MARCH 3, 2008 1:00 P N  ### ARCH 3, 2008 1:0		Dhusisi			me (First, Middle, La	ist)				2. Date of Deat	h	Vear Vear	3. Time of Death		
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Physician / Medical Examiner    Physician / Medical Examiner   Physician / Physic	<u>ē</u>	s 1 ar f Hea item ;		20a. Method of Dis	sposition		20b. Place of Dis	position (Name of				City or To	wn, State		
Physician / Medical Examiner    Physician / Medical Examiner   Physician / Physic	timo	t. Page tment o <b>tant: If</b> ijury or		4 ☐ Donation	5 Other (Speci	fy)	CHAMBER	S CREMATOR	Y 3-6-						
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Physician Medical Examiner  Due to (or as a consequence of):  Due to (or a				23a. Part1. Enter shock, or he	the disease, or comeant failure. List only	nplic ons that caused one cause on each lin	the death. Do not e	nter the mode of dying	g, such as cardiac	or respiratory arre	est,		Interval Between		
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a				disease or conditi	ion	_a. 45	CVP						Onset and Death		
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Female   F	9/2	ite be iysicia ne bur	<u>ca</u>			<b>_</b> d									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown  24a. Was an autopsy performed a teaching profession of completion of cause of death?  1   Yes   2   No   3   Probably   4   Unknown  24a. Was an autopsy performed a teach   Yes   2   No   1   Yes   2   No   Yes   Yes		- D 6		IE EEMALE:											
25. Was case referred to medical examiner.  26. Place of Death (Check only one)  27. Manne of Death  1	Ö	the death ce y the attendii ched for use	ysician/I	23b. Was decede in the past 1. 1 Yes 2	2 months?	1□Live birth 4⊡Pregnant at	2 ☐ Fetal death 3						*		
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)		ing After uner	ion	1 Natural	5 ☐ Pending	(Month, Day				280. Describe no	w injury occurre	на			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	ivisi	Atten death octor: y the	tificat	3 ☐ Suicide	6 ☐ Could not b	e 28e. Place of inju	ry - At home, farm, s . (Specify)		2 2 140	28f. Location (St City or Town	reet and Numbe n, State)	r or Rura	l Route Number,		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 10 / m elic X for X DV  JLA N BRECKER, modernte 5/lvex 9pvc = mode 2090 2  State  8. State  Registrar  MAD 0.6 2008				Du	21000	ecker n	no OME	1000	458	0	riar s	-	<b>とつうち</b>		
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MAIN V 0 2000 RAMINES JO JOSEPH CONTROL OF THE PARTY OF T		Sta Registr				32. jegistra	r's Signature	Conti			<u> </u>				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Anthony A. Crupi 4c. County of Death march /Medical 4a. Facility Name (If not institution, give street and number) Examiner Wicomica Lisbury Rehaba Nursing Ctr Dalisburg If Under 1 If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days 6/21/1925 Hours 126-16-8684 82 NY Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Berlin Worcester 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ms 23a or must be r 10 Audubon Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or item edical Examiner r 1 Yes 2 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No 1 ☐ Yes 2 🔀 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph J. Crupi Leiteria Alizio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Crupi / wife 10 Audubon Circle, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 <u></u> = ŏ 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) John Cemeterv 3/10/2008 Middle Village, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Part1. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) eon-/Medical Ducto (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events 2000 Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at the detached for 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 1□ Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of ath Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide To the Hospital 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 10 William H. Robins, M. D. 200 31. Date filed (Month, Day, 32. Registrar's Signature State MAR 0 7 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month N MICL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 28, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 □ M 2 🕱 F Hours 82 Guyana Director 218-04-5751 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Director Montgomery Maryland Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 7051 Carroll Avenue, Apt. 702 20912 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 X Widowed 4 ☐ Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ound be not and Mental F ဂ Joseph Shepherd Esther Shipley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 Is
any Injury or other trau Joy Charles - Daughter 7051 Carroll Avenue, Apt. 702, Takoma Park, Maryland 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 03/09/2008 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the perspective shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical as the b for use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn certificate 1□ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2[]Mo 1 Inpatient ို 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Watural (Month, Day 5 ☐ Pending investigation death. 1 Tyes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road acatominina Silver Spring, MD 20910 egistrar's Signature 31. Date filed (Month, Day, Year. State 2008 06 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 8:15 PM Christopher Dava11 FEB 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas Moore Nursing & Rehab. Prince George's Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1XM 2□F Days Hours Director 578-90-9342 46 MAY 6, 1961 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural," or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland | Prince George's Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 20743 517 69th Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Yes 2 🗖 If Yes, Give Year or Dates: 1 XNever Married 2 Married 2 X No 1 ☐ Yes 2 X No Completed by Specify 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Custodian University Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Drag Harlan Davall ျှ Sarah E. Shannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is other tran Sarah Davall/Mother 517 69th St. Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State iverdale Park 3/4/2008 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland 21. Signature of Funeral Service Life Service 22. Name and Address of Facility
Thibadeau Mortuary Service, PA M00956 933 Gist Ave., LL, Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician uman un and of wint disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): been signed by the attending physician should be detached for use as the hurial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an performed? 2 1 NO To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2☐ Ato Other: 4 Inversing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day 27. Manner of ath 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Whiteral 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 60100 02-29-8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MitminA AHMED, MD BLVD University Sail. 31. Date filed (Moath Day, Year) MAR 0 6 2008 32 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Raphael Douglas March 11 2008 0530 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert 9. Birthplace (State or Foreign Calvert Memorial Hospital
5. Social Security Number 6. Sex 7. Age (In yrs Prince Frederick C
If Under Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) ge (In yrs. last birthday) **Funeral** Days 1**⊠** M 2□ F Yrs. 41 Aug. 21, 1966 Director 579-04-2001 T'NUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Calvert Lusby 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 12659 Santa Rosa Circle

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 20657

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Funeral 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Opportunity Equal Employment ment Specialist

18. Mother's Name (First, Middle, Maiden Surname) Government 17 Father's Name (First, Middle, Last) Be Bobbie Douglas ပ Richard Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is me any injury or other transmones 19a. Informant's Name/Relationship (Type. Print) 12659 Santa Rosa Circle
Lusby Md 20657

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Shanita Douglas/wife 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/08 | Clinton, Md. Resurrection Cem. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee, 23a. P. It. Enter the disease, or complications has caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so the cardiacter of the cardiact 3910 Silver Hill Rd., Suitland, Md.20746 Approximate Interval Between Onset and Death Immediate Cause (Final Presmonio Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PSIS Se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a confequence of) Physician/Medical Examiner be executed Due to (or as a consequence of): signed by the attending physician IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by use tobacco Yes Yes 2 No 3 Probably 4 Unknown use alwhol 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 0 besity ones 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: T Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Merdono 111/08 D0060638

State Registrar

e 31. Date filed (Month, Day, Year)

N. HENDONCA.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A Acade

100, HOSPITAL

FREDERICK

20678

PRINCE

ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Beverly G. DeShong Mar 8 2008 2:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington NMS Healthcare of Hagerstown Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 V F Hours 162-22-1183 78 Sep 5, Director PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Washington Hancock 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 8882 Corner Road 21750 USA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pressor Clothing mfg. permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygie Important: If item 27 is marked other I any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin DeShong Myrtle Sipes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie A. McCarty daughter 8882 Corner Rd., Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 03/12/2008 Greencastle, PA 21. Signature of Funeral Service Nicensee 22. Name and Address of Facility Miller-Bowersox Funeral Home 521 S. Washington St., Greencastle, PA 17225 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dowlersa Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a conse uence of): disease or condition resulting in death) /Medical Examiner liabe es if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): burial physician Physician/Medical attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) g Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending Iniury n 24 hours after death.

The Funeral Director: A pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hosp within 24 hou To the Fune completely fi

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Khalid Waseem, MD

31. Date filed (Month, Day, Year) MAR 1 9 2008

1126 Opal Court, Hagerstown, MD 21740 32 Registrar's Signature G CAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2323

29d. Date signed (Month, Day, Year) 03-10-2008

Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3:48 pM Eleanor Prema Enjeti 2008 March 02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ■ F July 26, 1946 India 61 Director 218-66-7158 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or Items 23a or 28a-f show selcal Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Adelphi 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 India 2502 Fallingbrook Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian ģ 3 ☐ Widowed 4 🗷 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Physician Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Deva Krupavaram Bhattu Sudarshanam Enjetti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Sabena Gill - Daughter 300 Massachusetts Avenue, NW, Washington, D.C. 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 03/09/2008 Adelphi, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed ed by the attending physician and detached for use as the burial-transit Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contribution to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Define basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Sometime basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) D14/82 3-2-08 no completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, Maryland 20785 31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

MAR

06

Division or Vital Records, P.O. Box 68760. cate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I

Certification: To Be Completed by Physic	9 ☐ Unknown  Part II. Other significant conditions	9□Unknown  contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown					
			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
	25. Was case referred to medical	26. Place of Death (Check only one)						
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home	e 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n (Month, Day Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
cal		nysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred						

29c. License number

911 Russell Avenue, Gaithersburg, MD 20879

D19294

29d. Date signed (Month, Day, Year)

March 5, 2008

State Registrar 29b. Signature and

30. Name and add

31. Date filed

John R./Melnick,

itle of certifier

0 6

and manner stated.

ss of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

MD

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200° Month **Physician** 0059 march Helene Mae FRAZIER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Haipita altimore timore a Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F Director 11/27/1930 West Virginia 212-30-0370 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Marylan 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or ftems 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2√☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18022 Par Three Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 X Divorced filed within 72 hours Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Manufacturing Company Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary <u>Black & Decker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental 2 William W. Beale Hazel K. Phillips permit. Pages 1 and 2;
Department of Health an.
Important: If Item 27 is m. any injury or other 2. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAn Martin P.R. 937 Rose Hill Avenue, Hagerstown, Md. 21740
se of Disposition (Name of Date 20c. Location - City or Town, S 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/14/08 Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Volend 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS DAYS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last DAYS Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit MASS RIGHT LUNG 0 16/125 Due to (or as a consequence of): attending physician the for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ate has been signed by the a page 2 should be detached Yes 2 WNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY DISTASE 1 Yes 2 No 3 Probably 4 Unknown ARTGRUI 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has l autopsy performed? Yes 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this ( 28a. Date of Injury (Month, Day 27. Manner of Death 1 Natural funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea... ral Director: Aftr 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral I hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) con hi duo 041129 Surgeon MARCH 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-8 W. Ctto SIN. 41 HOSPITAL ALTERCONE, MARLY LAND 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State MAR 1 2008 Registrar 20.00

Saltimore,

Division or Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of	Maryland / D		artment of H rtificate of L		d Mental		ene No.	8	09036
	Physic		1. Decedent's Name (First, Middle, Last)  Geraldene A. Fox							of Death	10 <sup>ay</sup> 2	800	3. Time of Death 4:10 P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6411 Browns Quarry Road Sabillasville					eath	4c. County of Death Frederick				
	Funeral Director		215-26-1523	5. Sex 1 □ M 2 ☑ F	7. Age (In yrs. last birti 79 Y	hday) (rs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date (Mont	of Birth h, Day, Y	<sup>(ear)</sup> 928	9. Birthp Cour	place (State or Foreign ntry) MD
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation					1	Od. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	MD Fred	erick	Sa	bil	llasville						1 ☐ Yes 2 🎇 No
		Funeral Director	10e. Street and Number 6411 Browns Quarry Road 10f. Zip Code 21780 USA					What Coul	ntry?				
		erai	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba		? (Specify Yes	or No-	14. Rac	ce - Americ	
920		þ	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For d 1 ☐ Yes If Yes, Give Year or Da	2 <b>X</b> )No 9	Ì	f Yes, specify Cubai 1 □ Yes 2🛣 No	n, Mexican, P Specify:	uerto Rican, etc	c.)		ck, White, y: Whi	
21215-0036		To Be Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired.	luring most of	working	16	b. Kind of B	usiness/In	dustry
212			Elementary/Secondary (0-12) 7	College (1-	-4or 5+)		Homemake				Own	home	e
and			17. Father's Name (First, Middle, L.		**				Name (First, M die Sara				
Maryland			Parvin Lee S  19a. Informant's Name/Relationshi			Mailir	ig Address (Street a						Code)
			Richard Melvin	Fox hus			Browns (				-		
Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control of		State cemetery	crer Ch	sition (Name of natory or other place nurch Cem.	. 03	Date 3/14/200	08 (		le, M	)
Ball			21. Signature of Funeral Service Li	Bac John	01 11		Name and Addres						Home, Inc.
		Г	23a. Parly. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
	Physician: The law requires that the death certificate be executed with a standing physicien and this certificate has been signed by the attending physicien and a director, page 2 should be detached for use as the burial-transit.		Immediate Cause (Final disease or condition resulting in death)	_aA	myotropp	uc	Later	al !	clevo	2513			Onset and Death
				Due to (d	or as a consequence o	f):							~
		iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			aence of):							
		Examiner				f):							
68760,		dicai E		d	d								
O. Box		To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   16   9   Unknown   12   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   12   Fetal death   5   Other (specify)   9   Unknown   13   Ectopic pregnancy   16   Ectopic pregnancy   16   Ectopic pregnancy   16   Ectopic pregnancy   17   Ectopic							23d. Date of delivery Month Da			ery Day Year
<u>α</u>										Did toba	d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ MO 3 ☐ Probably 4 ☐ Unknown		
l Records,										Was an autopsy performe (es 2	prior to completion of cause of		
Vital			25. Was case referred to medical examiner?  Hospital:  Others  Others										
of	Phys rthis ral di		1 ☐ Yes 2 ☐ ₩6 27. Manner of Death	28a. Date of	patient 2 ER/Out f Injury 28b. Ti	me of	t 3 DOA Other	4 Nursii		e 5 Asidence 6 Other (Specify) d. Describe how injury occurred			
sion	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Atler completely filled in by the funer.	atio	1										
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)				reet, factory, office 28f. Location (Street and I City or Town, State)					d Number or Rural Route Number,	
		Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To t To t com	×	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  104359  104359  104359										
			30. Name and address of person w	7459	of death (Item 236) (1	ype.	JY.	Hager	stown	/	1/1	21%	742
		State Registrar 31. Date filed (Month, Day Year) 9 2008 32. Registrar's Signature											

To the Hospital or Attending within 24 hours a

To the Funeral I

Medical State

OH , wording out amounted

29c. License number

29d. Date signed (Month, Day, Year)

41F53000

WARCH 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

301 HOSPITAL DRIVE, GLEN BURNIE, HD, 20161 SUILLERMO JOSE COBABUATO

31. Date filed (Month, Day, Year) MAR 0 5 2008 Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:00A.M Agnes Elva GOLDEN March 10, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerford Place Washington Hagerstown 8. Date of Birth (Month, Day, Year)
July 7, 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F 89 172-18-8423 Pennsylvania Director 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Washington 1 Yes 2 No Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16710 Fairview Road 21740 U.S.A. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) time keeper aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Charles Plummer Lidia Catoni ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin F. Golden - husband 16710 Fairview Road, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State March 13. Rest Haven Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEBILIT

Due to (or as a consequence of): 2 yrs disease or condition resulting in death) /Medical Examiner 1246IMEN'S Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

120 VILLIAM E. 15/50 31. Date filed (Month, Day, Year) MAR 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certifier

11110 MEDICA CAMPUITO, SUITE 107, HATENSTOWN, MO 21742 32. Restrar's Signature

State

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0051395

29d. Date signed (Month, Day, Year)

			1 - For State of Maryland / Dep	partment of Health and Mental ertificate of Death	Hygiene 0 0 8	09039
	Dharaia		Decedent's Name (First, Middle, Last)	2. Date Mon	of Death	3. Time of Death
	Physic /Medi		Paul Andy Goldizen, Sr		ch 6, 2008	5:00a M
	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	ath
			13101 Goldizen Lane	Clear Spring	Washing	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min. 8. Date (Months Days Hours Min.	th, Day, Year)	rthplace (State or Foreign ountry)
			Usual Residence of Decedent	Apr	11 20,1932	W. Virginia
	show		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	B-fs	ctor	Maryland Washington Clear S	pring		1 ☐ Yes 2 ☐ No
	ith the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
	ath w	ral	13101 Goldizen Lane	21722	USA	
	be filed within 72 hours atter death with the Maryland lat Hyglene do ther than "natural", or Items 23a or 28a-f show event, it where I have marken must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- 14. Race - Am c.) Black, Wh	
36	rs att	y F	1 □ Never Married 2 M Married 1 □ M es 2 □ No If Yes, Give 1 1 / 1952	1 ☐ Yes 2 X No Specify:	Specify:	
21215-0036	2 hou	Completed by	6/1955	edent's Usual Occupation	16b. Kind of Busines	ite
215	nin 72 an 'na Mentilia	plet	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	Mobile N	•
212	d with	EO		ner/Self Employed	Parks	TOME
Þ	be filed tal Hygid d other event,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, A	Middle, Maiden Sumame)	
/ai		10	Andy Goldizen	Jenny Ours		
Maryland	2 8 9 10	Ι.	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural Route I	Number, City or Town, State,	Zip Code)
	s 1 and 2 if Health item 27 I			1 Goldizen Lane, Cl	lear Spring	MD 21722
Ore	M ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition	osition (Name of Date amatory or other place)	20c. Location - City o	r Town, State
Ë	ment:		`4 □Donation 5 □Other (Specify) Cedar L	awn Mem Pk 3/10/200	8 Hagerston	wn, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Donald Edwin Thomps		
_	40200		/ musics of vive	PO Box 310. Clear S	Spring. MD	21722
			/ 23a. Part 1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause opeach line.	nter the mode of dying, such as cardiac or respira	tory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	while Lung XIsea	$\varphi$	Oriset and Death
	/Medical Examiner		Due to (or as a consequence of):			\$7 cm-
		<u>.</u>	Sequentially list conditions,  I any leader to investigate  Due to for as a consequence of the conditions of the conditi	re		52 years
	insit	Examine	cause. Enter Underlying Cause (Disease or injury			
oʻ.	exect n and ial-tra	Еха	that initiated events c. Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dical	d. —			
9	tificat ng phy as th	0				
Вох	death certifi e attending p id tor use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 □ Live birth 2 □ Fetal death 3	⊒Ectopic pregnancy	23d. Date of de	divery
O. B	0 0 0	slcie	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month	Day Year
P.O	that the d ed by the detached	Phy	9 Unknown			
	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute t	
oro	requi	ted	mykysoma_		Yes 2□No 3□P	robably 4 Unknown
Records,	has b	Completed		24a.	Was an autopsy 24b. Were a prior to	utopsy findings available completion of cause of
<u> </u>		Co		1	performed? death? Yes 2☐No 1☐Ye	s 2 No.
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)	
o	S S S	To	1 Inpatient 2 ER/Outpatie		esidence 6 Other (Spe	ecify)
Ö	Atter	tion	1 Datural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 28d. Desc Work? M 1 ☐ Yes 2 ☐ No	cribe how injury occurred	
Division	Attending r death. ector: Atte by the fune	fica	3 Suicide 6 Could not be 390 Bloom of Injury At home form at		tion (Street and Number or R	ural Pouta Number
≧	after Dire	Certification:	4 Homicide determined building, etc. (Specify)		or Town, State)	urai moute mumber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to	the cause(s) and manner a	s stated.
	ne Ho 124 P 18 Fu Hetely	edical	(Check only 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the	time, date and place, and du	e to the cause(s)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
•			Harfredela MO	027898	3/7/0	8
			30. Name and address of person who completed cause of death (Item 23a) (Type		, / '	
St	10+1			mul St. Hager	town, MI	021740
	Sta Registr	_	31. Date filed (Month Day, Year)  MAR 1 1 2003  32. Rejistrar's Signature	Escale 3	•	
			The state of the s	Character Street		

			For State Registrar		State of Ma	ıryland / I	-	artment of F rtificate of		Mental H	ygiene Reg. No.	2008	09040
à.	Physici	an	1. Decedent's Name (First, I	Middle, Las	st)					2. Date of D	eath Day	Year	3. Time of Death
	/Medic			EZRA	PRESTO	N	G	EORGE		03	12	08	0755 <sup>M</sup>
C	Examin	ier	4a. Facility Name (If not insti WMHS BRAI					CUMBERI	r Location of Deatl	1	4c.	County of Death	
	Funeral		5. Social Security Number	6. S		(In yrs. last bi	rthday)	If Under 1 Year	If Under 24 Hrs.		irth	ALLEGAN 9. Birth	place (State or Foreign
	Director		234-38-8911	1.	XM 2□F	83	Yrs.	Months Days	Hours Min.	April	ay, Year) 18,19		tin. WV
	pug A		Usual Residence of Deceder 10a. State 10b. Co			10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	//anyla f sho ed at	ō		,	_								1 □Yes 2 No
	the N 28a-	Funeral Director	10e. Street and Number	Miner	al	F	Ceys	10f. Zip Code			10g, Citiz	zen of What Cou	intry?
	h with	i D	Rt. 1, Box	204				2672	16		US		,
	ems Ser mu	ner	11. Marital Status	. 204	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of H	lispanic Origin? (S an Mexican Puerl	pecify Yes or N		14. Race - Ameri Black, White	
20	or it	by Fu	1 Never Married 2		1 ☐ Yes 2 💢 N If Yes, Give	lo		1 □ Yes 2 No	Specify:			Specify:	_
-U03	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		3 Mary Widowed 4 □ Divo	edent's Ed	Year or Dates:	16a	. Dece	dent's Usual Occup	ation			Wh: nd of Business/tr	ite
<u>5</u>	hin 72 B. In "na Medic	Completed	(Specify only I	nighest gra	ide completed) College (1-4or 5		(Give life. l	kind of work done DO NOT use retired	during most of wor d)	rking			
7	ed with	Som	8			·′	T	ruck Driv	er		Tr	ucking	Company
and	be file tal Hy d oth event	Be	17. Father's Name (First, Mi	ddle, Last)					18. Mother's Nan	ne (First, Middl	e, Maiden	Surname)	
<u> </u>	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n iraumatic event, the Medi	۴	John Geor		Time Defeat	140	. 8.4 - 101			a O'Bri			
<u>0</u>	id 2 st tth and t7 is r traur		19a. Informant's Name/Rela	. ' '				ng Address (Street					p Code)
a)	f Heal	-	20a. Method of Disposition	e/ 50	J11	20b. Place c	f Dispo	1, Box 2	1	ser, WV Date		726 cation - City or T	own, State
<u> </u>	Page Tent o Int: If		1 X Burial 2 □ Crema 4 □ Donation 5 □ Oth			1		matory or other plac emorial G		March 1 2008		eyser,	W
Dallimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se	rvice Licen	Isee	7		2. Name and Addre	4 F104 ·	mith Fu			
	20 E # 9		Pous	not	Dull-			Rt. 2, B	ox 1-A	Burling	ton,		710
			23a. Part1. Enter the disease shock, or heart failure.	e, or comp List only	plications that caused one cause on each lin	4		A 3 6	K 4	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a. Acut	-		andal	hojas	lion			2 days
	Examiner				Due to (or as a	consequence	οτ):		3.8				*
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000	icate be executed physician and the burial-transit	al E)	in deality basis	- E	Due to (or as a	consequence	or):						
00	ficate be executed physician and the burial-transit	edical			_d								
XOC.	n certi	M/M	IF FEMALE: 23b. Was decedent pregnar	ıt .	23c. If yes, outcome			Ten			2	3d. Date of deliv	very
	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		1 □Live birth 4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify)				Month	Day Year
ر ا	at the	Physician/M	9 Unknown							00 00			
Ś	ires the signer	by	Part II. Other significant co		<i>-</i>		n the ui	naeriying cause giv	en in Part I.			se contribute to : ∃No 3⊟ Pro	the cause of death? bably 4 🛣 Unknown
cords,	requ been should	eted	1-+	01-	Many de	,				1			
ב ב	he law has ge 2 s	Completed	Marke	20	nosis					24a. Wa auto per	s an opsy formed?		opsy findings available ompletion of cause of
9	an: T tificate or, pa		25. Was case referred to me	edicat	·				26. Place of Dea	1□ Yes	2 No	1 ☐ Yes	2 ☐ No
>	ysicia is cer direct	o Be	examiner? 1 ☐ Yes _2 No		Hospital:	 nt 2	utpatien	t 3 DOA Oth	or:			☐Other (Speci	ifv)
5	ng Ph fter th neral	J: L	27. Manner of Death 1 ☐Natural 5 ☐ Po	anding	28a. Date of Injur (Month, Day	y 28b.	Time of	f 28c. Injur Wor		28d. Describe			<u> </u>
2	tendii eath. or: A the fu	catic	2 Accident in	vestigation ould not be				M 1 🗆	Yes 2 ☐ No				
	or At fifter d Direct in by	Certification:		etermined	28e. Place of inju building, etc	ry - At home, fa . <i>(Specify)</i>	arm, str	eet, factory, office		28f. Location City or To	(Street and own, State)	d Number or Rur	al Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death, the Tot the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a, Certifier	tifying Ph	ysician: To the best o	f my knowledge	e. death	occurred at the tir	me, date and place	and due to the	e cause(s)	and manner as	stated
	ne Hos ne Fur sletely	edical	(Check only 2 Med one)	tical Exam	niner: On the basis of and manner sta	examination ar	nd/or in	vestigation, in my o	pinion, death occu	irred at the time	e, date and	place, and due	to the cause(s)
	To th To th comp	Me	29b. Signature and title of ce	tifier				29c. Licens	e number			signed (Month)	
				Mr	tre			Doc	33280		Mo	rol 1	2,2008
			30. Name and address of po	rson who	completed cause of de	ath (Item 23a)	(Type,	Print)	haara -		216	3	
	Sta	to	31. Date filed (Month, Day,	Year)	32. Registra	r's Signature	×111	JE (101)	II) ETUL	I), NCL	O. C.	30d	
	Registr		MAR 2	0 200	8 Aldre		lan.	# T					
OHN	1H 17 Rev 1/20	001			TOWN	1	De la						

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DHMH 17 Rev 1/2001

08-0207	0	
Barbara	L.	Horn

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State of Maryland / Department of Health and Mental Hygiene

Jaibara E. HOIII		اک ا 1- For State Registrar	ate of Maryland		rtment of F tificate of L		i Mentai i		2 0	08 0904
Physicia Medical Examin	n/	1. Decedent's Name (First, Middl				31		2. Date of Deat	h	3. Time of Death
iledicai Examini	G I	Barbara Lynn F 4a. Facility Name (if not institution			4b.	City, Town, or L	ocation of Dea	Month March 14,	2008 4c. County of E	0850 hrs
r		Atlantic General Hosp				Berlin			Worcester	
Funeral Director		5. Social Security Number 212-70-7646	6. Sex 7. Ag	e (In yrs. Ia:		If Under 1 Year Months Days	If Under 24H Hours M		. IF	B. Birthplace (State or oreign Country)
any		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Location					10d. Inside City Limits
<b>*</b>	_		cester		Ocean Ci	tv				1 Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	003001			0f. Zip Code		10	g. Citizen of What	Country?
th the M		704 A Anchor (	Chain Rd.			21842			USA	
0036 within 72 hours after death with the Maryland giene. ret than "natural", or items 23a or 28a-f she Medical Examiner must be netified at once	Funeral	11. Marital Status  1 Never Married 2 X Ma	arried 12. Was Decedent Armed Forces?			ecedent of Hisp specify Cuban,		Specify Yes or No- to Rican, etc.)	14. Race - A White, e	American Indian, Black, etc.
s after ral", c	۾		orced If Yes, Give Year or Dates:			es 2 X No			Specify:	White
2 hour "natu	Completed	<ol> <li>Decedent's Education (Specific Elementary/Secondary (0-12)</li> </ol>	College (1-4 or		16a. Decedent's during most	Osual Occupation of working life.			16b. Kind of Busin	ness/Industry
036 rithin 7 rne. rr than	립	12			Photo	Manage	r		Drug S	tore
215-0036 be filed within 72 hours natal Hygiene ent, the Medical Exam		17. Father's Name (First, Middle,				1		ne (First, Middle, N	Maiden Surname)	
	To Be	Bobby K. Ham I  19a. Informant's Name/Relationsl			19b. Mailing A	ddress (Street	Kayree		ber, City or Town,	State, Zip Code)
MD id 2 shoulth and m 27 is aumatic		David J. Horn /	husband			•				MD 21842
or He		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from Sta		lace of Disposition		- 11	Date	20c. Location - Ci	•
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Sp	ecify:	Car	oe Henlo				Frankfo	
Baltimo permit. Page Department of Important: injury or ott	ļ	21. Signature of Funeral Service	Licensee Server	/					e Funera MD 2181	
Physician /Medical		23a Part 1. Enter the disease, or failure. List only one cause	complications that caused on each line.	the death.						
-xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclero			lar Disea	se			Death
•	1	Sequentially list conditions,	Due to (or as a conse	equence or)	:					
	je	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of)	:					
P sit	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of)	:				• • • • • • • • • • • • • • • • • • • •	
760, Ticate be executed g physician and the burial - transit	_ 1	X UNPENDED	d	Dr. TT	7 27 1	WE 077 0	/26 /00		<del></del>	
60, ate be only sicial le buria	Medical	IF FEMALE:	AMENDED 23a.			ME 88// 3	/26/08 ar	nh	23d. Date of de	livery
687 certific rding p	sician/I	23b. Was decedent pregnant in th past 12 months?	e 1 Live birth		2 Fetal		Ectopic preg	nancy	Month	Day Year
Box 687 The death certification in the attending properties as the	iysic	1 Yes 2 No 9 V Unk	nown 4 Pregnant at 9 Unknown	ume or dea	th 5 Other	(Specify)				
that the deatl	by Phy	Part II. Other significant conditi	ons contributing to death	but not res	sulting in the und	erlying cause giv	ven in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
ords, P.C.  w requires that s been signed is should be deter	8	Emphysema: Chron	ic Pancreatitis	s: Diab	etes			// 10		Probably 4 V Unknown
cord	ompleted							24a. Was a autop:	sy pric	re autopsy findings available or to completion of cause of
tal Rection: The certificate ector, page	ا د	25. Was case referred to medical						1 ✓ Yes 2		Yes 2 No
Vital ysician his cert directo	o Re	examiner?  1 V Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸 E	ER/Outpatient 3	10	of Death (Chec Other: Nurs		Residence 6	Other:
of Vital Recling Physician: The I	- 1	27. Manner of Death	28a. Date of Inju (Month, Day,Y		28b. Time of Inju				now injury occurred	
sion ttendi death. ctor:	을   	1 X Natural 5 Pend 2 Accident Inves	ng tigation				es 2 No			
Division of Vital Records, spital or Attending Physician: The law requint outs after death.  neral Director: After this certificate has been similal in by the funeral director, page 2 should be a feed of the funeral director, page 2 should be a feed of the funeral director, page 2 should be a feed of the funeral director, page 2 should be a feed of the funeral director, page 2 should be a feed of the funeral director, page 2 should be a feed of the funeral director, page 2 should be a feed of the feed of	Certification:	3 Suicide 6 Could determ	not be	ury - At hor	me, farm, street, f	actory, office bu	ilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
		29a. Certifier 1 Certifying Ph	ysician: To the best of my niner:On the basis of exam							
To To Com	Medical	29b. Signature and title of certifier	and manner stated.	-		29c. License				(Month, Day, Year)
		June D_				O.C.M	I.E.		March 15, 20	008
		30. Name and address of person		,			MB 015			
Stat		Ana Rubio MD. Assi	stant Medical Exam		11 Penn Stre	et, Baltimor	e, MD 2120	רנ 		
Registra	_	MAR 1	7 2008	- agratur	H. Son	all!				

08-01858 Emory Holland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nory Holland		State of Maryland / Departmen  1- For State Certificate			and	Menta	l Hyg		Reg. No	20	08 0904
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)						Date of De	ath Day	Year	3. Time of Death
edical Exami		Emory S. Holland Sr						March 9,	2008		1358 hrs
		Facility Name (if not institution, give street and number)     Anne Arundel Medical Center	4	b. City, Tov Annapo		cation of L	Death		ľ	Anne Arund	
Funeral	-	Social Security Number 6. Sex 7. Age (In yrs. last birthda	y)	If Under	Year	If Under 2	24Hrs.	8. Date of B	irth (M	M/DD/YYYY) 9. I	Birthplace (State or Foreign
Director		213-64-1175 <sub>1</sub> M <sub>2</sub> F 53	Yrs.	Months	Days	Hours	Min.	May :	17		Country) Maryland
		Usual Residence of Decedent	- 11								10d. Inside City Limits
w any	٦	10a. State 10b. County 10c. City, Town or I Maryland Baltimore Baltim									1 Yes 2 YNo
rland -f sho		faryland Baltimore Baltim  10e. Street and Number	IOI	10f. Zip C	ode				10a. C	Citizen of What C	11
e Marror 28a	Directo	1410 Cypress St. Apt 16			122	6		ľ		USA	•
b, MD 21215-0036 and 2 should be filted within 72 hours after death with the Maryland leath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Mediral Examiner must be notified at once.			3. Wa:	s Decedent	of Hispa	nic Origin	? (Spec	ify Yes or N	io-	14. Race - Am	erican Indian, Black,
leath v	Funeral	1 Never Married 2 Married Armed Forces?	If Yo	es, specify	Cuban, M	/lexican, F	uerto Ri	can, etc.)		White, etc	
after d	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Yes 2X					_,		Black
hours natura	ed b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)		t's Usual O ost of worki					U U	S Nav	-
36 in 72 l han "l liral I	plet	College (1-4 or 5+)	nn	ing	с D.	ogoi	ari n	~		commiss	
d with	Completed	17. Father's Name (First, Middle, Last)	. PP	ring						en Surname)	<u> </u>
21215-0036 utilin 7 Mental Hygiene. marked other than cevent, the Media	Be (	Ralph M. Holland				Vivi	an	B1ake	<u> </u>		
21 nould I no Mer is man	10										ate, Zip Code) 21061
MD 2 shot alth and 1 is 1 i		Dorcell Holland (Former Wife) 7  20a. Method of Disposition 20b. Place of D						Del:	L G	len Bu	rnie, Md. or Town, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after  pergartment of Health and Mental Hygiene.  Important: If item 77 is marked other than "natural",  injury or other traumatic event, the Medical Examiner.		4 Vower 2 Compation 3 Removed from State crematory	or oth	her place)				7-08			ille, Md.
ti Pag trent trant:		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee								ry, P.	
Bal permi Depar Impo injur	'n.	Larry S. Beese MOD 483								Md. 2	
Physician		23a. Part I. Enfer the disease, or complications that caused the death. Do not e	nter t	he mode of	dying, s	uch as car	diac or r	respiratory a	arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical caminer	r y	failure. List only one cause on each line. Immediate Cause (Final disease a. Intracerebral hemorrha	ge								Death
Carriffer		or condition resulting in death)  Due to (or as a consequence of):									
	er	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			_						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
cuted ind transit	Exa	events resulting in death) Last Due to (or as a consequence or).									
exe an a	edical	X UNPENDED AMENDED 23a, Pt II, 27	per	ME g8	8 4/	2/08 a	mh				
760, cate be physici	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy								23d. Date of del	
Box 6876( death certificate the attending physical for use as the b	Physician/M	past 12 months?  1 Live birth 2 Pregnant at time of death 5	=	etal death ther (Speci	3 <u></u>	Ectopic	pregnan	су		Month	Day Year
Box e death the atte	ysį	1 Yes 2 No 9 Unknown 9 Unknown									
Ç. ₽. ₽.	by PI	Part II. Other significant conditions contributing to death but not resulting in	n the	underlying	ause gi	ven in Par	t I.				e to the cause of death?  Probably 4  Unknown
ds, P.C requires that seen signed ould be deta		Cocaine use; hypertension						24a. W		A Partie and a second	e autopsy findings available
ord aw rec as bee	Completed							au pe	topsy rforme	d? deat	
tal Rec sian: The l certificate l ector, page	5				. 51	· ( D · · · t) · /	Ob a di a		s 2	No 1 ✔	Yes 2 No
ital ician: s certif	BB	25. Was case referred to medical examiner? Hospital: 1 ✓ Inpatient 2 ER/Outp	natien		10	of Death (		Home 5	Re	sidence 6 0	Other:
of V g Phys fter thi	ا ا	27. Manner of Death 28a. Date of Injury 28b. Tit				at Work?			be hov	v injury occurred	······································
On ending ath.	iti on	1 X Natural 5 Pending (Month, Day, Year)			1 Y	es 2	No				
Division of Vital Records, lat or Attending Physician: The law requir at dearth.  al Director: After this certificate has been is led in by the funeral director, page 2 should I	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fam	n, stre	et, factory,	office bu	uilding, etc		28f. Location			r Rural Route Number, City
Divi Hospital or 24 hours afte Funeral Dir	Cert	4 Homicide determined (Specify)						<del></del>			
Division of Vital Frontee Brysician: Within 24 hours after death within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) Medical Examiner: On the basis of examination and/or inv	occu estiga	irred at the ation, in my	time, da opinion,	te and place death occ	ce, and ourred at	due to the c the time, d	ause(s ate and	s) and manner as d place, and due	stated. to the cause(s)
To t With To t	Medical	and manner stated.  29b. Signature/and title of certifier				number					(Month, Day, Year)
		()( a. Osle M)			O.C.N	Л.E.			1	March 11, 20	08
		30. Name and address of person who completed cause of death (Item 23a)				115			_		
		Laron Locke MD. Assistant Medical Examiner 111	Pen	n Street,	Baltin	ore, Mi	2120	01			
S	tate	31. Date filed (Month, Day, Year)  MAR 1 2 2008  32. Refistrar's Signature	0	1.10							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Feb 29 2008 6:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare -The Pines Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2**V**F Months Days Hours Min. 2/4-32-1729 Usual Residence of Decedent Director Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits P.O. Box 342 10f. Zip Code 1 ☐ Yes 2 No Director Anne's 10e. Street and Number 10g. Citizen of What Country? Hawkins Lane 2/6/1 US A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Hawkins Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone else's home WOrk 10 Domestic Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, ti once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ada Sewell Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21617 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City of Town, State Cemetery, crematory or other place) Anna Burns Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Hope, Maryland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Roseville 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henry Funeral Itome, P.A.

510 washington St. Cambri

23a. P. II. Enter the disease, or complications that caused the bath. Do not enter the mode of dying, such a cardiac or respiratory arrest,

Immediate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral hemorehere **Physician** eus /Medical Due to (or as a consequence of): Examiner ere proviscular Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an nis certificate has director, page 2: autopsy perform 24 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

MICHALL

610

ar's Signature

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROWLE

State of Maryland / Department of Health and Mental Hygiene 0 0 8

09044

			1 - For State Registrar	State of Marylan		tificate of		Reg.		0 0 0
	Physici	an	Decedent's Name (First, Middle, Last Guy Edgar Irv					2. Date of Death Mar 8,	<sup>Day</sup> 008 <sup>Year</sup>	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give			4b City Town o	r Location of Death		4c. County of Dear	5:15 pм
	Examin	er	Williamsport N				msport		Washing	
	Funeral Director		213-14-1307	ex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Ye	9. Bir 1916 MD	thplace (State or Foreign puntry)
	wo.		Usual Residence of Decedent  10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	a-f-sh	ctor	MD Washin	gton Wi	lliam	sport				1 GYes 2 □ No
	efter death with the Maryler or Iteme 23e or 28e-f ehow infrer must be notified at	al Dire	10e. Street and Number 154 N Artizan	Street		10f. Zip Code 2179	5		. Citizen of What Co	
980	within 72 hours efter death with the Marylend ene. then "neturel", or iteme 23e or 28e-f ehow I.a McJical Exercitor must be notified at	i by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		1 ☐ Yes 21 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	od within 72 hours e glane. er then "neturel", o , its Mudical Exert	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)			pation during most of work d)	king 168	b. Kind of Business ouilding	supply co
121	Hyol Hyol Ther nt,		6th grade  17. Father's Name (First, Middle, Last)	0	LI	uck dri		e (First, Middle, Mai	iden Sumame)	
and	d a b	To Be	John S. Irvin				Hannah		,	
Maryland	hall ret	_	19a. Informant's Name/Relationship ( Walter David I	/ con	19b. Mailir P.O.	ng Address (Street Box 88	and Number or Rus Clear S	ral Route Number, C pring, M	ity or Town, State ID 21722	Zip Code)
Baltimore,	Pages 1 end nent of Heelt ant: If Item 2 ary or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State B	emetery, crer airs	vition (Name of matory or other plan Valley	1 20	08' C	c. Location - City or lear Spi	ring MD
Balt	permit. Pages 1 Depertment of H Important: if ite eny injury or ot		21. Signature of Funeral Service Licer		De P	Name and Addre Onald E	ess of Facility dwin Tho 310 Clea	ompson F	uneral 1	Home,Inc
1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not ent	er the mode of dy	ng, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a congestiv	le he		Failure	٧		months
	Examiner			Due to for as a consequence by blood Cr	neuce of):	1 Emia				months
	p is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ		,	, ,			, ,
	rificate be executed og physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	c a	The second second	inal b	leeding			months
68760,	e be e /sicien e burit	calE		d.						
	E O e	Medical	IF FEMALE:							
P.O. Box	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	Physician/A	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.			o the cause of death?
Vital Records,	The law requested has been page 2 should	Completed						24a. Was an autopsy performed	d? death?	utopsy findings available completion of cause of
Vita	Physician: 'this certifica	Be	25. Was case referred to medical examiner?	Hospital:		0+	200	th (Check only one)		
ō	Phys this ral di	To I	1 Yes 2 A6	28a. Date of Injury (Month, Day Year)	28b. Time of	. 50 50.		ome 5 Residence 28d. Describe how		ecify)
ion	Attending I r death. ector: Aftar by the funer	atlor	1 Natural 5 Pending 2 Accident investigation		Injury		rk? ]Yes 2 □No			
Division	를 를 들	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, office		28f. Location (Stree City or Town, S		tural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifying Pr (Check only 2 Medical Examone)	nysician: To the best of my kno minar: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
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			Cynthia Ku	the -sa	ds, 100	Delan 1	7451	bla == 1=	WILL OF	Action Cl
51	67		30. Name and address of person who Cynthia Kuttner	- Sands mo	1 (1 am	Sport N	Michael	rome, 13	y land -	Artizan Street 21795
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 24a per verbal, 878;04/14/98dhb 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** 3/1/2008William A. Jackson III 7:28amM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine 5610 Tiffany Drive Churchton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes 4/8/1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F Days Hours Min. 54 132-36-6824 ΝÝ Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Churchton MDAnne Arundel 1 TYes 2XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 20733 5610 Tiffany Drive USA filed within 72 hours after death v Hygiene. yther than "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 Notes
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 2[XNo 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Corporate Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William A. Jackson Jr. Patricia Kirkpatrick 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Kelly Jackson 5610 Tiffany Drive Churchton, MD 20733 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 3/5/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Data 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause part of line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mister disease or condition resulting in death) /Medical Due to r as consequence f): Examiner troph if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760 physician s the burial Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) teen signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed direc or, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1□ Yes 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Iniury investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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amend lines 16a-b per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 03/04/08 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 1916 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month <sup>Day</sup> 2008 **Physician** March 2, Willie Lou James 12:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yes 9/13/1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 ₩ F Yrs Director 409-48-9989 76 Tennessee Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10b. Counfy Show 10d. Inside City Limits item 27 is marked other than "natural"; or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9440 Newbridge Dr., #113 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Associations Office Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: if item 27 is marked other the any injury or other traumatic event. the 12th Bookkeeper--Bookkeeping Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Jasper Barran Margaret D. Plunk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine A. Tillotson/Daughter 8104 Coach St., Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4□Donation 5 Other (Specify) Kalas Crematory 3/4/08 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home Mul Whi 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine the death certificate be executed Cause (Lisease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the hurial Physician/Medical use as IF FEMALE: 23c. if yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 Yes 2 No 1□ Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3□ DOA Hospice Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation ours after death.
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filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I To the Hospitai 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. 29a, Certifier Medical 29b. Signafure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064615 w March 3, 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve A. Wroblewski, M.D. 1355 Piccard Dr., Rockville, MD 20850 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) MAR 0 4 2008 Registrar

Physician (Inclication Marie Layman Marie La			í	1 - For State Registrer	orate or mary		artment of F rtificate of			geg. No.	0	0304	I
Figure 1   Facility Name (if not enstitution, give stoked and number)  Frostburg Village Nursing Home  Frostburg Village Nursing Home  Social Security Number  215-26-1628   10 m 20 F   7. Age (fin yet, list birthday)    10 m 20 F   7. Age (fin yet, list birthday)   10 m 20 F   7. Age (fin yet, lis		Physicia	an		_	Layman			2. Date of Dea	ith Day	Year	3. Time of Death	M
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Physician //Medical Examiner  Physic	_ g_ je	tent: f jury o		* 4 ☐ Donation 5 ☐ Other (Specify)	S				3/16/2008	Cresap	town	MD	
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) Them 126907 MARCH 14,200g	-			) The	llin		026	907		MARCI	4 16	1,2008	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARDIT SIDHO, M.D. 925 BISHOPWASH RD. CUMBERLAND, MD 21500				30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type,	Print)	HRNO	IMRE	DIAM	Mr	17120	
THE CONTRACTOR OF THE PROPERTY							1 1 11 11 11	1 1 1 2 1		2 1 1 1 1 1 1 1	7、1 * 13-	J 011300	

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			1 = For State Registrar Amended#31			Department of Certificate of			giene Reg. No. 2	08 09048
			Decedent's Name (First, Middle, Last					2. Date of Dea	ath	3. Time of Death
	/sicia		Ronald Will:	iam Lavelv.	Sr.			March	10, 2008	
	ledic. amine	1000	4a. Facility Name (If not institution, give	street and number)			or Location of Deatl	h	4c. County of	
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Fune Direc	_		219-00-3339	X 7. Age (Ir QM 2□F 51	yrs. last bin	Yrs. Months Day:			, 1956	9. Birthplace (State or Foreign Country) Takoma Park,
land	38	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
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h the	Tou a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
th wit	4	a	117 Central Ave	enue		2173			US	
r dea	E I	Iner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puerl	specify Yes or No- to Rican, etc.)	- 14. Race Black	- American Indian, k, White, etc.
permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show	Exemin	<u>۾</u>	1 Never Married 🏖 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2X N			Specify:	
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Ald be Al	tic ev	10 B	William Clair La	avely, Sr.			Iona N	Marie Wa	tson	
short short	E I		19a. Informant's Name/Relationship (T			. Mailing Address (Stree				
end 2	ner tr		Mary V. Lavely - V			117 Central	Avenue,	Brunswic		
Peges 1	iry or off		20a. Method of Disposition  XXBurial 2 Cremation 3X1 4 Donation 5 Other (Specify	Removal from State	cemeter	Disposition (Name of ry, crematory or other p ven Gardens		13-2008	Frederi	City or Town, State
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cate be executed	the burial-to	cai	resulting in death) Last	Due to (or as a co	onsequence	of):				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and	hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregnar 5 □ Other (specify)	осу		23d. Date Mor	e of delivery hth Day Year
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pltel c	<del>-</del>	9		1	a. Inneulada		time, data and place	e and due to the	cause(s) and ma	nner as stated
Hos Pun	ately filled		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of m liner: On the basis of ex and manner stated	amination an	e, death occurred at the id/or investigation, in m	opinion, death occ	urred at the time,	date and place, a	and due to the cause(s)
To the Hospitel or Attending Physician: The law requires that within 24 hours effer death.  To the Funeral Director: Affer this certificate has been signed.	completely filled	Medicai (	(Check only 2 Medical Exam	iner: On the basis of ex	amination an	d/or investigation, in m	nse number	urred at the time,	date and place, a	and due to the cause(s)  (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per in 6 878 4-4-08 yt 198 tale of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 11:12 A<sup>M</sup> INDRAWATI **MEHTA** MARCH 4, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY Year If Under 24 Hrs. 8. Date of Birth

Davs Hours Min. (Month, Day, Year) 5. Social Security Number 0850 217–72 - 8050 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) Days 1 □ M 2 □ **X**F Months 91 FEB. 14, 1917 INDIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ▼Yes 2 No MD. MONTGOMERY OLNEY 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 4800 CONTINENTAL DR. 20832 INDIA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify: Specify: ASTAN INDIAN 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KHEMCHAND DATTA SAVITRI VAID 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PRAMOD C. MEHTA/SON 4800 CONTINENTAL DR., OLNEY, MD. 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 3-5-2008 RIVERDALE, MD. 21. Signature of Funeral Service Lifensee 22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P. A. Chamburas M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATRIAL FIBRILLATION YEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

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death.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

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Examiner

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Item 27 other to

Department of Important; If It any Injury or of once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine burial-tran Physician/Medical the as for use \$ Completed director Be Certification: To funeral filled in by the

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AMEMIA

FAICURE MCART 3132

1 Yes 2 No 3 Probably 4 Inknown

25. Was case referred to medical examiner?

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No NIA 26. Place of Death Check only one)

1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Hospital: 1 Manpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number D0058542

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Dav. Year)

MARCH 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONCORD STREET # SUD KENSINGTON, MD 2089\$ DR. LIBUSE HEINZ- MOMULOVIC, 10605

Li hickanz - Thomas Toire

State Registrar

0 6 2008 MAR



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND#9perFH3-10-08, BMW, Moco Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 **Physician** Helen Benedict Maccado March 3, 7:30 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) INDIA **Funeral** Months Days Hours Min. 216-94-4842 80 Director July 23, 1927 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified 1 ☐ Yes 2 X No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22908 Woodfield Road 20882 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc be filed within 72 hours after 1 ☐ Yes 23**%** If Yes, Give Year or Dates: 2XXNo 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other I any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ambrosis Salins Deborah Karkada ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mayrose Barnes/Daughter 22908 Woodfield Road, Gaithersburg, MD 20882 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 8, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Am Kilo C MARY 500 University Blvd, W., Silver Spring, MD 20901 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End-Stage Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a nonsequence off be executed Exami and burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, **pe** by 1 Yes 2 No 3 Probably 4 Jnknown <u>Gastrointestinal Bleeding</u> Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate Division or Vital 1□ Yes 2KXNo 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospital: 1 🔲 Yes XX No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Hospice To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) MAR 2008 06

Genevieve Wroblewski, MD

29b. Signatu

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(us)

29c. License number

D64615

6001 Muncasater Mill Road, Rockville, MD 20855

29d. Date signed (Month, Dav. Year)

March 4, 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0905 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Maude Franklin Meade 2008 $\mathbf{A}^{\mathsf{M}}$ March 3 9:55 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Eldercare Spa Creek Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 227-16-2856 85 Director July 13, 1922 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1350 Blackwalnut Court 21403 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 3 Married 1 Yes 2 If Yes, Give Year or Dates: 2**X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Service U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry W. Edwards Martha Bourne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Demma/daughter 1350 Blackwalnut Court Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 Removal from State 3/6/2008 4 Donation 5 Dother (Specify) Annapolis, Maryland Hillcrest Mem. Gardens 21. Signature of Tuneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical Examiner

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Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate	b		
Cause (Disease or injury that initiated events resulting in death) Last	c		
	.d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use co	ntribute to the cause of death? 3 ☐ Probably 4 ☐Unknown
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 ☐ No	
25. Was case referred to medical		1 Yes 2 No  24a. Was an autopsy performed? 1 Yes 8 No	3 Probably 4 Unknown  D. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death	1 Yes 2 No  24a. Was an autopsy performed? 1 Yes 9 No  n (Check only one)	3 Probably 4 □Unknown  b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Aursing Hore (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work?	1 Yes 2 No  24a. Was an autopsy performed? 1 Yes 8 No	3 Probably 4 Unknown  b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No

29c. License number

132036

Drue Cheshy Mos

29d. Date signed (Month, Day, Year) 3/4/300 P

State

Registrar

within 24 hours a

29b. Signatura and title

31. Date filed (Month, Day, Year)

MAR 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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State Registrar

DHMH 17 Rev 1/2001

Medical

Eli Poza, MI 31. Date filed (Month, Day, Year) MAR 1 1 2008

1620

29b. Signature and title of certifier

29a. Certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

20022313

29d. Date signed (Month, Day, Year)

Happystown, MD

241-2

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person

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23a) (Type, Print)

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Physic		1 - State Registr <i>a</i> r	,		artment of H rtificate of L		4	Reg. No.	000	03024
Physic	9	Decedent's Name (First, Middle, Last	st)				2. Date of De	eath Day	Year	3. Time of Death
/Medi		Hattie Mary	Montgomery	7			March	-	2008	7:45A M
Exami		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. Co	unty of Death	
Funeral	r	Prince Georges 5. Social Security Number 6. S	Hospital ex 7. Age (In )	yrs. last birthday)	Che If Under 1 Year Months Days	Ver v If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	av. r <i>ear</i> )	Cou	
Director		577-40-8393 Usual Residence of Decedent	X	79 ''			Aug. ?	1,192	8 Wa	sh.,DC
land ow		10a. State 10b. County	10c.	. City, Town or Lo	ecation					10d. Inside City Limits
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re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1□Yes 2☑ No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, pecify:	etc.
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215-0036 thin 72 hours af ie. "natural", or Medical Exam	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work ()	ing			•
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Maryland Id 2 should be file Ith and Mental Hy 77 is marked oth traumatic event		19a. Informant's Name/Relationship (			Fastern		al Route Numb NE	er, City or To	own, State, Zi	o Code)
re, M s 1 and 2 if Health Item 27 i		Sandra Brown/d 20a. Method of Disposition	aughter	Wast	Eastern	DC 20	019 Date	20c Locat	tion - City or T	own State
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	23c. If yes, outcome pf pro 1 Live birth 2 Live Pregnant at time 9 Unknown contributing to death but not 28a. Date of Injury (Month, Day Year building, etc. (Sp. 1) 1 Live Proposition of the basis of examination of the basis o	egnancy Fetal death of death o	Ectopic pregnancy Other (specify)  Int 3 DOA Other  Seet, factory, office  Ceet, factory, office  Ceet, factory, office	26. Place of Deatler:  26. Place of Deatler:  4 □ Nursing Ho y at ⟨? Yes 2 □ No  ne, date and place, pinion, death occur	23e. Did  1 □  24a. Was auto perf. 1 □ Yes  h (Check only) me 5 □ Res 28d. Describe  28f. Location ( City or To and due to the red at the time	tobacco use  Yes 2 1 1  an psy ormed? 2 1 No one) idence 6 1 how injury o  Street and N wn, State)  cause(s) an date and pl	Month  contribute to  No 3 Pro  24b. Were aut prior to codeath? 1 Yes  Other (Speciacurred)  Mumber or Run  and manner as ace, and due	the cause of death? bably 4 Munknown opsy findings available ompletion of cause of 2 No  al Route Number, stated. to the cause(s)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3130 PM March 13, 2008 PAUL MARTORANA VICTOR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/18/1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1**X** M 2□ F Days Hours Min. New York 057-16-8872 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Jarrettsville Director MD. Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 United States 3617 Adwocate Hill Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify White Completed by 3 Widowed 4 Divorced 3/08 1050. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aerospace Machinist 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evence. Governale Martorana Marie Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type. Print) 3617 Advocate Hill Dr. Jarrettsville, MD. Margaret Martorana (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Cremation 3/19/2008 Hampstead, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Sergice Ligensee E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metasta colon concer Inonth **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Martorana, Victor fawl msco 270579 Division or Vital/Records, P.O. Box 68760, Sequentially list conditions, Due to (or as a conse juence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 24a. Was an autopsy performed? 1∐ Yes 2D(No certificate Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2/2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number D45530 ralloun ned 3-14-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sulte 200, 602 s Atwood, Belair 21014

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2008

SIUASA

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 05:30 P M March 01 2008 James Murray MacDonald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 802 Coxswain Way #208 Annapolis If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 01/22/1939 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Michigan 194-30-3449 69 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at 1 ☐ Yes 2 No "natural", or Items 23a or 28a-f sh edical Examiner must be notified Director Annapolis Maryland | Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 United States 802 Coxswain Way #208 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1961 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Executive Appliances permit. Pages 1 and 2 should be filed very permit of Health and Mental Hygis Important: If Item 27 Is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Ronald MacDonald Hildegard Leo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. MacDonald/Wife 802 Coxswain Way #208, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 03/03/2008 Edgewater, Maryland Kalas Crematory injury o 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home any HM 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0 Years **Physician** disease or condition resulting in death) OW /Medical as a consequence of): Examiner Disease OVONAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy jo Month in the past 12 months? Year 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 g 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 2□ No certificate 2 1000 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 20 No 1 Tyes 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P \$His 28a. Date of Injury (Month, Day Year) Sompletely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Reath 28c. Injury at Work? Certification: After To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined 1 [Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical State Registrar

Tose 31. Date filed (Month, Day.

MAR 0 1 2008

29b. Signature and title of certifier

Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

Annapalis,

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JOSEPH PAUL MALONEY FEBRUARY 28, 2008 4:20 P M **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign (In yrs. last birthday, MARCH 18, 1961 WASHINGTON, DC **Funeral** Days Hours 1 XM 2 ☐ F 46 219-64-1924 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Examiner must be notified at 1 ☐ Yes 2 No GRASONVILLE Director **MARYLAND** QUEEN ANNE'S 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö UNITED STATES 21638 Items 23a 968 CHESTER RIVER DRIVE Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Specify: WHITE 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. SHELTERED WORKSHOP 8 LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY BECK THOMAS GERALD MALONEY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 968 CHESTER RIVER DRIVE, GRASONVILLE, MD 21638 THOMAS GERALD MALONEY/FATHER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 2, 2008 STEVENSVILLE, MARYLAND 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEARE CREMATION MARCH CENTER CREMATION AND FUNERAL CARE P.A., 814 BESIGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licenses Will E Borne M00672 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each in e. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final iveek **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Dav in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► 400 24a. Was an autopsy performed Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 atient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27 Manner of Death After (Month, Day Year, Injury 1 Datural 2 Accident 5 ☐ Pending investigation 1 TYes 2 TNo death. in by the Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Try Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) digital manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature of certifie 200 completed cause of death (Item 23a) (Type, Print) 30. Name and 32. Registrar's Signature 31. Date filed (Mo State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 2008 1:00P Flora Elizabeth Main March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Mt. Airy Kline Hospice House If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🖾 F 90 220-10-5899 May 24 1917 Director Brunswick, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 TNo Frederick Knoxville MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21758 IISA 3810 Petersville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Compher's Crossroads n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Operator Inn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Anna Louise Heller Raymond Percy Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John T. Williams Funeral Home 19a. Informant's Name/Relationship (Type. Print) of Health a Patsy Davies, Daughter 100 Petersville Road, Brunswick, MD 21716 20c. Location - City or Town, State Pages 1 s 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition St. Mark's Cemetery 3/12/08 1 ■ Burial 2 Cremation 3 Removal from State ō Department of important: if any injury or once, 4 □ Donation 5 □ Other (Specify) 21. Signature of Furieral Service License 100 Petersui 11e Road, Brunswick, Md.21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mys condial **Physician** disease or condition resulting in death) /Medical Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Due to (or 5 Examine The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical ass attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? res 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 (Specify) H 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident hours after death uneral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. within 24 29d. Date signed (Month, Dav. Year) 29c License number 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Day,

Montclaire

trederick

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Hague

700

	1 - For State Registrar	ate of Maryland		rtment of F		Re	eg. No.	08	0905
ρ.	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
Physician /Medical	Victor Ray	mond Olds				March	01	2008	1:21 p
Examiner	4a. Facility Name (If not institution, give street	and number)		4b. City, Town, o	r Location of Dea	th	4c. County	of Death	
n marks of	1610 Olney Sandy Spring				y Spring If Under 24 Hr	a La a de		lontgo	
-uneral	5. Social Security Number 6. Sex	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours Mir	. (Month, Day,	Year)	Cour	
irector	442-28-3160	88	113.			November	11,1919	0k1al	Юша
>	Usual Residence of Decedent  10a, State 10b, County	10c. City,	Town or Loc	cation				1	0d. Inside City Lim
s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Maryland Montgomer	v		Sa	ndy Spring	>			1 □ Yes 2 🗷 I
Item 27 is marked other than "natural", or items 23a or 28a-f sho, other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Maryland Montgomer  10e. Street and Number	, , , , , , , , , , , , , , , , , , , ,		10f. Zip Code	ndy bpring		0g. Citizen of	What Cour	ntry?
Dil be		D 1			20860			U.S.	A
iner must	1610 Olney Sandy Spring	as Decedent Ever in U.S.	13. V	Vas Decedent of F		Specify Yes or No- erto Rican, etc.)		ce - Americ	can Indian,
Fun	A A	rmed Forces? Yes 2 No				erto Rican, etc.)	Bla	ck, White,	etc.
by by		Yes, Give ear or Dates: <b>WWII</b>	1	☐ Yes 2 <b>X</b> No	Specify:		Specii	y:	White
1 P			16a. Deced	ent's Usual Occup	oation	asking .	16b. Kind of B	usiness/In	dustry
t, the Medical E	(Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. L	OO NOT use retire	d)	orking			
om the	8	onoge (1 larel)		Farmer			Spri	ing La	ke Farm
ent,	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, i	Maiden Surna	ne)	
To B	Gideon Ramon Olds				]	Lucinda Sch	enore		
aumatic event, the Market Comp	19a. Informant's Name/Relationship (Type. F	rint)	19b. Mailin	g Address (Street	and Number or	Rural Route Numbe	r, City or Town	, State, Zij	Code)
in tra	Joanne T. Olds - Spous	e	1610	Olney Sand	y Spring	Road, Sandy	Spring,	Maryl	and 20860
t t	20a. Method of Disposition	cor	ce of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or T	own, State
ر اح	1 x Burial 2 ☐ Cremation 3 x Removed 4 ☐ Donation 5 ☐ Other (Specify)	Arlir	ngton N	ational Ce	metery 0	3/12/2008	Arlingto	n, Vi	rginia
important; if item 27 is r any injury or other traur once,	21. Signature of Funeral Service Licensee	12001	Hi	Name and Addr nes-Rinald 800 New Ha	i Funeral	Home, Inc. venue, Silve	er Spring	g, Mar	yland 2090/
ician	23a. Part 1. Inter the disease, or compile tion shock, or heart failure. List only one call immediate Cause (Final disease or condition	ns that a sed the death. use on a ch line.  Atherosclerot:	Do not ente	er the mode of dy	ng, such as card				Approximate Interval Betweer Onset and Death Years
hysician and the burial-transit and the burial-transit and lical Examiner	Sequentially list conditions, if any, leading to immediate cause. E. i.e Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque	ence of):						
been signed by the attending priy should be detached for use as the letted by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	yes, outcome pf pregnan □Live birth 2□Fetal o □Pregnant at time of dea □Unknown	death 3 ath 5	Ectopic pregnand Other (specify)			ħ/	ate of delivionth	Day Year
be d	Taren out of summand	ting to death but not result	ting in the u	nderlying cause gi	ven in Part I.				the cause of death bably 4 □Unkn
nas je 2						24a. Was a autop perfor 1  Yes	rmed?	. Were aut prior to c death? 1 ☐ Yes	opsy findings avai ompletion of cause 2 \( \text{No} \)
is certificate director, pag o Be Col	25. Was case referred to medical	hal.		100		Death (Check only of	ne)		
dire	1 ☐ Yes 2 🔼 No	1 Impatient 2 E		IL OUDON		Home 5□ Resid		<del></del>	rify)
funeral dir	27. Manner of Death 2 1 🛣 Natural 5 🗌 Pending	8a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe h	low injury occi	nieu	
the state of the s	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 2	Be. Place of injury - At hon building, etc. <i>(Specify)</i>	me, farm, str		Yes 2 No	28f. Location (S City or Tou	Street and Nun vn, State)	nber or Ru	ral Route Number,
completely filled in b		n: To the best of my know On the basis of examinati and manner stated.	vledge, deat ion and/or ir	h occurred at the overstigation, in my	time, date and pl opinion, death o	ace, and due to the ccurred at the time,	cause(s) and r date and place	nanner as e, and due	stated. to the cause(s)
Ne th	29b. Signature and title of certifier			29c. Licer	se number		29d. Date sigr	ed (Month	, Day, Year)
- 0	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				D51860		March	4, 200	18
	30. Name and address of person who compl	eted cause of death (Item	23a) (Type.	Print)				-	
	Jonathan Fish, M.D., 10				ryland 210	)44			
State	Od D. J. Wood (Marth Day Vens)								
State Registrar	0.0000	32. registrar's Signati	T. A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#23a Per Phy G877 3/31/08 JH

Reg. No.

Reg. No. &23PII 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 1,2008 5:50а м **Physician** S. Pierce Ruth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 3148 Gracefield Road #317 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 10/21/1925 **Funeral** Days 1 ☐ M 2 🔀 F 82 Germany 107-20-7840 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Silver Spring Montgomery MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20904 3148 Gracefield Road #317 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: <u></u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5 + Elementary/Secondary (0-12) High School permit. Pages 1 and 2 should be flied win Department of Health and Mental Hygient Important: If Item 27 Is marked other that any injury or other traumatic event; the Items Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanka Bayer Friedrich Schapira ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)2090419a. Informant's Name/Relationship (Type. Print) 3148 Gracefield Road #317 Silver Spring, Md Francis Pierce/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3\_Bemoval from State Chesapeake Crem. 3/05/2008 Beltsville, Md 4 □ Donation 5 □ Other (Specify) PHINE TO PADO SERVICE, P.A. 21. Signa re & Funeral Service ... luly & 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Non Small Cell Lung Cancer, Immediate Cause (Final disease or condition years **Physician** <del>Dementia of</del> disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cus to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) physician Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Brady Tachy Syndrome with Pacemaker Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 2 2 No certificate l 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? After t Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

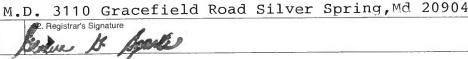
Division or Vital Records, P.O. Box 68760 Hospital or Attending hours after death. e Funeral C

within 24 hou To the Fune completely fi P

> State Registrar

Stuckey John 31. Date filed (Month, Day, Year) MAR 0 6 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D23649

29d. Date signed (Month, Day, Year)

March 4,2008

		1 - For State Registrer	Otate of Ivial		epartment of F Certificate of a		Reg.	2000	09061
25	,	1. Decedent's Name (First, Middle, Last)	)				Date of Death     Month	Dev. V	3. Time of Death
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Exami		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of Dea	ath
		JOHNS HOPKINS	HOSPITAL	_	BALTIMO	RE CIT	4		
Funera	1	Social Security Number 6. Sex	x 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	rthplace (State or Foreig
Director	r	214-48-3606	]м 2√Д F	61 Y	rs. Months Days	Hours Min.	Sept. 26	,1946	ountry) Maryland
P ,		Usual Residence of Decedent							
within 72 hours after death with the Maryland ane. than "natural", or Itame 23a or 28a-f show the Madical Examinar transt be notified at		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
8a-f	5	Maryland Washing	ton		Boonsbo	ro			1 ☐ Yes 2√2 No
be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or itsme 23s or 28s-f show ent, the M-clical Exactine froutted at sevent, the M-clical Exactine froutted at	Directo	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What C	ountry?
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e L	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race · Am	
or afte		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:	,,	Specify:	
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nati	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(	Decedent's Usual Occup Give kind of work done of	during most of work	ing 16t	b. Kind of Business	s/Industry
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filed v Hygie other t		12		cer	tified Nurs			Healthc	are
tal t	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Mai	iden Sumame)	
	5	Donald W. Palme				Mary N	Marie Smit	th	
~ ~ ~ = =	0	19a. Informant's Name/Relationship (Ty			Mailing Address (Street a			•	
eat n		Cindy M. Hoffman	(Daughte:		631 Mt. Len	a Road Bo	onsboro,	Maryland	21713
S		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R	lamoual from State	20b. Place of 0 cemetery	Disposition (Name of , crematory or other place		Date 200	c. Location - City or	r Town, State
permit. Pages Department of i Important: If its any injury or o once.		4 Donation 5 Other (Specify)	emoval from State	· -	on Cemetery	· · · · · · · · · · · · · · · · · · ·	08 <sup>19</sup> ,	Boonsbor	o, Maryland
permit. Page Department Important: If sny injury or once.		21. Signature of Funeral Service License	90		22. Name and Addres		.L. Davis	Funoral	<b>Ч</b> ото
20 5 2 8		To The least	Desic Mon	1414	12525 Brad				
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	FAILL	ot enter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death IMONTH
cate be executed  physicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c		):	EMIA			1 MONTH
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by the attending physici	hysician/Medica	in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □Live birth 2   4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	livery Day Year
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aw requires that the death certifi is been signed by the attending i 2 should be detached for use as	Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions con	ospital: 1 Inpatient 28a. Place of Injury building, etc.	Petal déath ne of death not resulting in t  APA  2 ER/Outp  (ear) 28b. Tir Inju	the underlying cause give  HYPERTEN  Patient 3 DOA Other  The of University Work  M 1 DOA  The of University Work  M 1 DOA  The of University Work  Th	26. Place of Death 26. Place of Death 37: 4 \( \text{Nursing Ho} \) 7 at 7 es 2 \( \text{No} \)	1 Yes  24a. Was an autopsy performed 1 Yes 2 The Check only one)  The Signature of the Sign	Month  co use contribute to 2 No 3 P  24b. Were a prior to death? 1 Yes  e 6 Other (Speinjury occurred	Day Year  o the cause of death?  robably 4 □Unknown  utopsy findings available completion of cause of secify)
aw requires that the death certifi is been signed by the attending i 2 should be detached for use as	Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	1   Live birth 2   4   Pregnant at tin 9   Unknown   Itributing to death but it	Petal déath ne of death not resulting in t  ONAPY  2 DEP/Outp  28b. Tir Inju  At home, farm Specify)  my knowledge, kamination and/	oatient 3 DOA Other working to the underlying cause give the underlying cause give the underlying cause give the underlying cause give the underlying a DOA Other working the underlying t	26. Place of Death 27. 4 \( \text{Nursing Ho} \) 26. Place of Death 37. 4 \( \text{Nursing Ho} \) 37. 4 \( \text{Nursing Ho} \) 38. 76s 2 \( \text{No} \) 39. 10. 4 date and place, binion, death occurrence.	1 Yes  24a. Was an autopsy performed. 1 Yes 2 Am Check only one  me 5 Residence. 28d. Describe how in the control of the caused at the time, date	Month  co use contribute to the contribute to th	Day Year  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of  s 2 No  ecify)  ural Route Number,  s stated, e to the cause(s)
aw requires that the death certifi is been signed by the attending i 2 should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 4 Pregnant at tin 9 Unknown  atributing to death but it  DK3 D  ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y)  28e. Place of Injury building, etc. (  idicien: To the best of refr: On the basis of ey and manner state.	Petal déath ne of death not resulting in t  APA  2 ER/Outp  2 Bb. Tir Inju  At home, farm (Specify)  my knowledge, tamination and/d.	on the control of the underlying cause gives the underlying at the underlying cause gives the underlying the underlyi	26. Place of Death  26. Place of Death  37. 4   Nursing Ho  rat  47. Yes 2   No  19. date and place, pinion, death occurre	1 Yes  24a. Was an autopsy performed. 1 Yes 2 Am Check only one  me 5 Residence. 28d. Describe how in the control of the caused at the time, date	Month  co use contribute to 2 No 3 P  24b. Were a prior to death? 1 Pes  e 6 Other (Speinjury occurred	Day Year  o the cause of death?  robably 4 □Unknown  utopsy findings available completion of cause of s 2 No  ecify)  ural Route Number,  s stated, e to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the tuneral director, page 2 should be detached for use as the bu	Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 4 Pregnant at tin 9 Unknown  atributing to death but it  Pul M  Drace  Ospital: 1 Inpatient  28a. Date of Injury (Month, Day Y  28e. Place of Injury building, etc. (  sicien: To the best of exercises of exercises)	Petal déath ne of death not resulting in t  APA  2 ER/Outp  2 Bb. Tir Inju  At home, farm (Specify)  my knowledge, tamination and/d.	the underlying cause give HYPERTEN  Patient 3 DOA Other  The of University Work  The of University Wor	26. Place of Death  26. Place of Death  37. 4   Nursing Ho  rat  47. Yes 2   No  19. date and place, pinion, death occurre	24a. Was an autopsy performed 1 Yes 2 1 Yes 2 1 Yes 2 2 Yes	Month  co use contribute to the contribute to th	Day Year  o the cause of death?  robably 4 □Unknown  utopsy findings available completion of cause of s 2 No  ecify)  fural Route Number,  s stated, e to the cause(s)

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Effield Mary Elizabeth Pearce 29, 12:05 PM 2008 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Severna Park 103 Water Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State of Foreign Country) Caicos 8. Date of Birth (Month, Day, Year) July 28, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 1 F 253-36-1211 Yrs. 1916 Turks & 91 Island Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at Severna Park MD Anne Arundel 1 ☐ Yes 2 X No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21146 British 103 Water Street Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (M)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 10. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home lith and Mental Hygir 27 is marked other r traumatic event, II other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lilian E. Frith Pages 1 and 2 should be George Dellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 103 Water Street Severna Park, MD 21146 permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is eny injury or other trau once. Marilyn D. Higgs/ Daughter Mar. 04, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory 2008 4 Donation 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home wsom 495 Gov. Ritchie Hwy, Severna Park, MD 21146 ames co art 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rimmediate Cause (Final disease) r condition resulting in death) NENMON Layou Physician /Medical Due to (or a a consequence of): Examiner SYRYE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2017 181A 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 101 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy 1 Yes 20 No certificete rs after deam.
ral Director: After this cerum. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03,03,2008 HANDY ENZ Kunmi Majekodunmi, MD 063726 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TORPO COURT 7200 MARTLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Brown & Sport MAR 0 4 2008

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 March Agnes Loretta Pryor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ivista (0 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🗶 F 12, 1918 Maryland 218-14-2040 89 May Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f st any Injury or other traumattc event, the Medical Examiner must be notified. Director LaPlata Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20646 7710 Bumpy Oak Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ Xio Baltimore, Maryland 21215-0036 Specify. 9 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Tda Charles H. Pryor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8150 Port Tobacco Road, Port Tobacco, Md. 20677 Nephew Calvin S. Thomas 20b. Place of Disposition (Name of cemetery, crematory or other place) March 10, 25t. Josephs Catholic Church 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Pomfret, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lice Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. MUU668 4270 Hawthorne Rd., Indian I disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death 1 Live birth Month in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown Nalete 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? ension 24a. Was an has page 2 perform 2 ☐ No certificate 1□ Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital Other: 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061652 Mh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 304 Waldorf MD

Registrar

State

31. Date filed (Month, Day,

Year)

2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 12:12 AM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Home 4b. City, Town, or Location of Death Examiner Somerset to/Ks 5. Social Security Number (State or Foreign Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M M 2□F 3 Yrs Director 218-20-6949 the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 1 ☐Yes 2 No la or 28a-f sh t be notified Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 2185 "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than ", Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Aoute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 1th Hon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once, 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State Delmor Ve Pince Williams, St. 12008 4☐Donation 5☐Other (Specify) Signature Frenal Service Licensee Name and Address of Facility 21853 Smith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5-104/3 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months 5 Other (specify) ☐Yes 2☐No the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification: To 6 ☐Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner Jeath Injury tural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) MAR 0

6 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Vivian W. Rehfield 5 112 A M March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Saint Agnes Baltimore Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 KY 6. Sex 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 3/9317 1934 (4ar) 73 Days 485-34-2106 1 □ M 2√ E Director Usual Residence of Decedent 10c. City, Town or Location Odenton with the Maryland 10b. County Anne Arundel 10d. Inside City Limits r 28a-f show notified at 10a. State MD 1 ☐ Yes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ns 23a or 7 must be n 525 King Malcolm Ave. 21113 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Funeral Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 致录No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🔼 No Specify þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Gibson Kenneth Fulcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12306 Greenspring Ave. Owings Mills, MD 21117 Ray Rehfield 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/5/2008 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Servi of igensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 23a. Parti: Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annapolis, MD 21401 Immediate Cause (Final disease or condition resulting in death) Brain days Anuxic **Physician** /Medical Due to (or as a consequence of): Dischemic Cardio mytopathy Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diffice Diarrhea Clusty) Jium
Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Mellitu 1 ☐ Yes 3 Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□No 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical ( 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier avin Mahmood MD 03-02-2008 1-19514

State Registrar

31. Date filed (Month, Day, Year) MAR 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Raistrar's Signature Mayue.

900 Caton Avenue Balkmore IMD, 21229

REHFIELD, VIVIAN

Tavin Mahmood, M.D.

State of Maryland / Department of Health and Mental Hygiene  1 - For State Registrer  Certificate of Death Reg. No.								09066				
			1. Decedent's Name (First, Middle, Last)					2. Date Mor	of Death	Day Ye	3. Time of Death	
	Physicia /Medic	_	June Ray	Regai	1				Ma	ſ :	3 200	
	Examin		4a. Facility Name (If not institution, gi		er)		4b. City, Town,		f Death		4c. County of D	
			15866 Frederick Rd.				Woodbine  If Under 1 Year   If Under 24 Hrs.   8, Date 6			of Birth	Howard  Birth 9. Birthplace (State or Foreign	
	Funeral			Sex 7 1 □ M 2 <b>X</b> F	Age (In yrs. I 54	ast birthday) Yrs.	Months Days		Min. (Moi	722/19	)53	Country) MD
	Director	-	Usuel Residence of Decedent									
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "netural", or Itams 23a or 28a-f show other traumatic event, the Marical Examinal must be notified at		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits 1 □ Yes 2  No
		ţō	MD Howard Woodbine									
		Director	Too. Shoot and remoon				10f. Zip Code	_		10g.	Citizen of Wha	at Country?
		<u>a</u>	15866 Frederick Rd. 21797  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spering Yorks) 15. Was Decedent of Hispanic Origin? (Spering Yo					nin2 (Chasifu Va	or No.	USA 14 Bace	American Indian,	
		Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married	12. Was Decede Armed Force 1 ☐ Yes 25	s?	S. 13.	If Yes, specify Cu	ban, Mexican	n, Puerto Rican, e	etc.)		White, etc.
36	ırs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes XXN	Specify:			Specify:	White
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working					t of working	16t	o. Kind of Busin	ness/Industry	
215	within 7 ene. than "n	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)					or woming	Charles Klein, Inc.		rlain Inc	
	ed wil	Con	12			Cus	tomer Se		er's Name (First,			kiein, inc.
nd	tal Hydral Hydrau even	Be	17. Father's Name (First, Middle, Lass Benjamin Burrou						e Ray	MIQUIE, MAI	den Sumame,	
Z	should be filed within and Mental Hygiene. s marked other than tumatic event, IL. M.	ပို	19a. Informant's Name/Relationship			10h Maili	na Address (Stree			ral Route Number, City or Town, State, Zip Code)		
Maryland	d 2 sho		Joseph C. Spayed				6 Freder					
Baltimore, I	1 and Health tem 27	1 18	20a. Method of Disposition	t, iiubbaiia	20b. P	lace of Dispo	osition (Name of matory or other p		Date			ty or Town, State
	Pages nent of I int; if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from Sta			rroll Cr		y 3/4/2	80c	Vinfield	d, MD 21784
Ħ	artme orter injur		21. Signature of Funeral Service Lic								Cromat	tory, P.A.
m	permit. Pages 1 and 2. Department of Health a Importent; If Item 27 is eny injury or other trau		Coloff 1	lell-		11:	212 W O	ld Lib	erty Rd.	. Win	field,	MD 21784
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	sed the deat	n. Do not en	ter the mode of d	ying, such as	cardiac or respir	atory arrest,	,	Approximate Interval Between Onset and Death
		5 1	Immediate Cause (Final disease or condition	. met	restat	· C	neast	Co	mcer			
			resulting in death)  Due to (or as a consequence of):								14	
		_										/
		nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	eath certificate be executed attending physician and for use as the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):						
8760,	siciar b buris	Sal		d								
9	ificate g phy as the	edic										
Box	h cert endin	M/us	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth  2 □ Fetal death  3 □ Ectopic pregnancy							23d. Date of		
	death	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown								Mona	,
P.0.	at the d by tl etach	Phy	9 Unknown	contributing to deal	th but not res	ulting in the	inderlying cause	given in Part i	1 23	e. Did tobac	cco use contrib	ute to the cause of death?
	w requires that the de been signed by the should be detached	by	Patti. Other significant conditions continuing to doubt but not recovery with a second great and					1 ☐ Yes	☐ Yes 2☐No 3☐ Probably 4 ☐Unknown			
ő		Completed							24	24a. Was an 24b. Were autopsy findings available		
3ec	elav has je 2	dm								autopsy	d?/ dea	or to completion of cause of ath?  Yes 2 No
a	(0 L	e Co										165 20140
Ē	Physician: this certificant	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Ing	atient 2	ER/Outpatie	ent 3 DOA	None.	ursing Home 5	/	ce 6 □Other	(Specify)
o			27. Manner of Death	28a. Date of (Month,	Injury Day Year)	28b. Time Injury	of 28c. In	jury at vork?	28d. De	28d. Describe how injury occurred		
<u>i</u>	Attending r death. sctor: Afte by the fune	atlo	Natural 5 ☐ Pending (Montal, Day Year) Injury Wolk:  2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No							8f. Location (Street and Number or Rural Route Number,		
Division of Vital Records,	or Atter de Director in by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	280. Place 0	f Injury - At h , etc. (Speci	ome, farm, s fy)	treet, factory, offic	Э	28t. Lo	y or Town,	et and Number State)	or Hural Houte Number,
۵		Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								ner as stated.	
	Hospitel 24 hours a Funerel etely filled	edical	29a. Certifier 1 Certifying (Check only 2 Medical Exone)	aminer: On the bas and manne	is of examina	ation and/or i	nvestigation, in m	y opinion, de	ath occurred at the	ne time, date	e and place, an	d due to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certified	1/1/	MO		29c. Lice	ense number	21.511		d. Date signed	(Month, Day, Year)
			Affi	// V	_	•	D		3184		3/4	108
	5 (1w		30. Name and address of person wh		of death (Ite		, Print)	11/1 -	troat 1	- 10	nick	4001701
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Electrical State  Registrar  31. Date filed (Month, Day, Year)  MAR 0 6 2008 Market							near	,	12021101			
	regist	120	1419 FLP (	- 5000	A STATE OF THE PARTY OF THE PAR	1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mathura Singh March 4, 2008 7:59 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2 □ F Director 212-29-6415 72 March 18, 1935 Guyana Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes ★☐ No Director Mary land Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6482 Boch Road, Apt. 309 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by Specify: Asian Indian 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seebalack Singh Tetri Singh ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilian N. Bacchus/Daughter 3313 Lauriston Place, Fairfax, VA 22031 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 8, permit. Pages Department of Important: If it any Injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2008 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that cau, d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 4 hours after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours at To the Funeral D

31. Date filed (Month, Day, Year) State Registrar MAR 06

29b. Signature and title

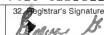
Anjum Qazi,

certifier

MD

2008

30. Name and address of person with bempleted cause of death (Item 23a) (Type, Print)





29c. License number

29d. Date signed (Month, Day, Year)

			1- State of Maryland Dep State of Maryland Dep Inf G877 3/25/08	artment of Health and N Hificate of Death	ental Hygier ا Reg	ne No o o o o	00000				
			Decedent's Name (First, Middle, Last)	2. Date of Death	/						
,	Physici	an			Day Year	М					
e la	/Medic	Su. 20 C	William Eugene Sasser  4a. Facility Name (If not institution, give street and number)	March 3,	2008 4c. County of Death	12:36 a					
	Examin	er									
			Shady Grove Adventist Hospital  5. Social Security Number 6. Sex 7. Åge (In yrs. last birthda	Rockville  if Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Mon t go	place (State or Foreign				
	Funeral Director		281-46-9952 1™ 2□F 60 Yrs.	Months Days Hours Min.	Jan. 3, 1	948 Oh	intry)				
	A.		Usual Residence of Decedent								
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits				
	Mar fied	io	Maryland Montgomery	Germantown			1 ☐ Yes 2 ☑ No				
	r 286	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	untry?				
	s 1 and 2 should be hied within 72 hours after death with the Marylar f Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. other traumatic event, the Medical Examiner must be notified at		20141 Century Blvd., #115		USA						
	deat ms (	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer Black, White					
9	after or ite mine		1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 1966—	1 ☐ Yes 2 ☐ No Specify:		Specify: Whi					
8	ral",	ξ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	XX.to openy.		opeony. Will					
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밀	be fil tal H d otl	Be	17. Father's Name (First, Middle, Last)		, ,	ien Sumame)					
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<u>la</u>	2 sh and Is m		( ),	ling Address (Street and Number or Ru	_						
	1 and 2 Health em 27 I			3722 Queen Mary Dr:		Location - City or					
Ore	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, c	rematory or other place) Man	rch 6,	. Location - City of	Town, State				
Ē	men ant:				2008 A1	exandria,	Virginia				
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 2090								
8	requires that the death certificate be executed  EX  Wedical  By Additional Action and a control of the attending physician and a control of the detached for use as the burial-transit		23a. Part1. Enter the disease, or complications that cause the death. Do not e				Approximate Interval Between				
			Immediate Cause (Final								
1			disease or condition resulting in death)  a.   ELECTROMECHANICa  Due to (or as a consequence of):	II DISSOCIACION			Acute				
			Acute Coronary S		Acute						
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ó	exe		resulting in death) Last								
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	ne dear the att hed for	icis	in the past 12 months?  1 □ Yes 2 □ No  4 □ Pregnant at time of death	B∐Ectopic pregnancy  □ Other (specify)		Month	Day Year				
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	ires that the de signed by the a be detached f	by F	Part II. Other significant conditions contributing to death but not resulting in the			the cause of death?					
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ta	an: tiffica tor, p		25. Was case referred to medical	26. Place of Dea	ath (Check only one)						
>	Physician: this certificatal director,	To Be	examiner?  1 Yes 2 Not Hospital: 1 Inpatient 2 R/Outpat	ient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residenc	e 6 □Other (Spe	cify)				
Division or Vital Records,	g Phys er this eral dir		27 Manne of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injur		28d. Describe how	injury occurred					
0	Attending Frdeath. ector; After	atio	Accident investigation (Month, Day Year) Injur								
<u>Vis</u>	Attend r death. ector; / by the f	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S		ural Route Number,				
	al or s afte	Certification:	Salaring, etc. (Speary)		,						
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate in completely filled in by the funeral director, page	edical (	29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Pheck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	the Hospital hin 24 hours a the Funeral upletely filled	ledi	one) and manner stated.	29c License number	204	Date signed (Mont	h Day Yearl				
	or with	Σ	29b. Signature and title of certifier	29c. License number	290	. Date signed (Mont					
	1701		1 1 TONE NORTH IN	D16458		March 4	, 2008				
	, -		30. Name and address of person who completed cause of death (Item 23a) (Type								
			Thomas E. Dooley, M.D. 17904 Geo	rgia AVenue Olr	ey, Maryl	and 20830					
18 4	Sta		31. Date filed (Month, Day, Year)  MAR 0 6 2008  32 degistrar's Signature	rgia AVenue Olr							
	Regist	rall	MENT O COOL MANUEL TO 10. 10								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 02 29 OLTU SNYDER 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mandrin Hospice House Harwood <u>Anne</u> <u>Arundel</u> If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗗 F Director 11/2/1916 213-36-1332 91 Annapolis, MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2625 Compass Drive 21401 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 2 No <u>}</u> 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Levy Rebecca Zell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Annapolis, Helene Sachs Daughter Bristol Circle MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/2008 Kneseth Israel Cem Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Aervice Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. rarfi. Enter the di lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart a ure. List only one cause a each line. Approximate Interval Between Onset and Death Imme to te Cause (Findisease or condition resulting in death) PAILUNG 30 **Physician** KES TCUTE /Medical ue to (or as a consequence of): **Examiner** PNEUMONA IWL Sequentially list conditions, it any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Y EARLS CUPO attending physician and burial-trar Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗓 No the 9∏Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 10ther (Specify) ANDIN HOPE 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 [The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier harel 03, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANA MO MYOI DEFENSE J. La ENTA . Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 5 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mont3/3/2008 0102 Leah Loretta Svat 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Months Days Hours 284-05-0405 1 M 2 X 93 5/25/1914 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Tyes 2XXNo Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21401 USA 9203 River Crescent Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Parker William Puls

2818 Seasons Way

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Royal Cemetery

nce of)

DON

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

3/6/2008

12 Ridgely Ave. Annapolis, MD 21401

22. Name and Address of Facility Hardesty Funeral Home, p.A.

Annapolis, MD 21401

utrecoobral blood

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Glenshaw, PA

Pages 1 and 2 should be filed within 72 hours after death with the Maryland a or items 23a ner must b Examiner 9 Baltimore, Maryland 21215-0036 "natural", Medical wental Hygiene.

'c/ is marked other than "ry traumatic even" Department of Health ar Important: If item 27 is any injury or other trauonce.

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

by

Completed

Be

၉

19a, Informant's Name/Relationship (Type, Print)

1 Burial 2 □ Cremation 3 □ Removal from State

23a. Part Enter the disease, o complications that caused the shock, or heart failure. List only one cause on each line.

Daughter

Due to (or as a conset

Due to (or as a consequence of

Barbara McKinnon

4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service licensee

0

20a. Method of Disposition

7

Immediate Cause (Final disease or condition resulting in death)

**Funeral** 

Director

28a-f show

**Physician** /Medical Examiner

physician

After this death. within 24 hours after death To the Funeral Director:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical by Completed Be Medical Certification: To

esques flary liet constone, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe death? 212 No 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide √Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2001 Madecare 30. Name at Haddress of person who completed cause of death (Item 23a) (Type, Print) Annapolis, Judy Herbert, M.D. 32. egistrar's Signature 31. Date filed (Month, Day, Year) MAR 0 5 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2008 **Physician** 2003 M 2 March Alice G. Sharps /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 23 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2√2 F 1935 Maryland 212-34-0091 Director Usual Residence of Decedent . 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
Health and Mental Hygiene.
tem 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Anne Arundel Edgewater Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 USA 4070 Old Muddy Creek Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Crownsville Elementary/Secondary (0-12) College (1-4or 5+) State Hospital 12th n Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. Priscilla Collins Charles Sharps ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tia K. Thomas(Daughter) 4070 Old Muddy Creek Rd. Edgewater, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chews UM Church 3-8-08 West River, Md. 4 ☐ Donation 5 ☐ Other (Specify) Hame Rease of MciliSons Mortnary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 arry MOUS 83 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner exastance if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year ò 5 ☐ Other (specify) detached o the 9 Unknown signed by t I be detach Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed Yes 2 certificate or Vital 25. Was case referred to medical examiner? Be 1 Yes 82 No
27. Manner of Leath

1 Natural

2 Acri 26. Place of Death (Check only one) Impatient Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ this spital or Attending Phhours after death.
neral Director: After th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred Certification: Division 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rege 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Judy Joseph Herbert MD

MAR 0 5

2008

31. Date filed (Month, Day, Year)

Registrar's Signature

21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 16 2008 MARCH 2:00 aM KARL MYRON SMITH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Chester River Hospital Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | July 29 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** <sup>Year)</sup> 1922 1**⊠**M 2□ F New Jersey 85 Director 138-14-6313 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Oueen Anne's Chestertown 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number ö 417 McGinnis Rd. 21620 U.S.A. or Items 23a Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 9 is marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Tunis D. Smith Nettie Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is,
any injury or other traus Karlyn Jean Smith (wife) 417 McGinnis Rd. Chestertown, MD, 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State 3/17/08 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) Kent Cremation 21. Signature of Funeral Service Liberas 22. Name and Address of Facility Galena Funeral Home of Stephen L M00510 118 West Cross St. Galena, 21635 23a. Part1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or cur dition resulting in leath) **Physician** FAILURE TO THRIVE /Medical Due to (or as a consequence of) **Examiner** ALZHEIMERS DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe PNEUMONIA certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Hospital or Attendi
 24 hours after death.
 Funeral Director: A completely filled in by the To the Hospital or within 24 hours at To the Funeral D

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and addy



ess of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

H0062423

29d. Date signed (Month, Day, Year)

21620

Division or Vital Records, P.O. Box 68760,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 13th 162588

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 E. Anherom St. Hagustown JUDITH MIBAOUA, TUS

6 ☐ Could not be determined

22. Registrar's Signature

31. Date filed (Month, Day, Year)

2 Accident

4 ☐ Homicide

3 ☐ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

P.0. Vital Records, o

within 24 hours a To the Funeral I Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Dear 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** PAUL R STALEY 2008 March /Medical 12:20 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. Frederick 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Hours 1 M 2 □ F Months Days Min 215-20-9270 Yrs Apr 6, 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland Frederick Frederick 1 ☐ Yes 2X No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21703 7029 Arbor Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ﷺYes 2 ☐ No WWII/ If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Wholesale Supply permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important; If item 27 is marked other tha any Injury or other traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Staley Brown Charles Paul Letita 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathryn Staley/ Wife 7029 Arbor Drive, Frederick, Maryland 21703 Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Mar 19, 2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Keeney & Basford P.A. Funeral Home 106 Fast Church St, Frederick, Maryland 21701 of Funeral Service Liversee 21. Signatur M00706 I 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Physician LUNG MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underson Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical for use as the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Id be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ icate has been siç , page 2 should b 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification:

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NID 200 61410

MARCH, 15,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED WEST GAFFAR SEVENTH STREET

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician**  $A^{M}$ March 11 2008 0554 Mary Louise Side /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Laurelwood Care Center Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛱 F Yrs. Director 83 FEB 5, New York 063-18-7729 Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "naturel", or items 23a or 28a-f ehov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No by Funeral Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 64 Hoover Court 21921 United States permit. Pages 1 and 2 should be filed within 72 hours after death v. Depertment of Health and Mentat Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a any injury or other traumatic event, the Medical Examinat must ance. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify 3 ¥ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 In Her Own Home Homemaker 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Griffin Rose Fikes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Side/Nephew 64 Hoover Court, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 12. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 21. Signa ure of Funeral Service Licenses 1) original Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** END STAGE Demensia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown MIDDM FAILURE 70 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No REFLIX 24a. Was an autopsy performe has e 2 DEPRESSION this certificate 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: After this c funeral dire Medical Certification: To 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident Director: / 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide Certifying Physiciep: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 054073 11MAROS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONE NEWGS75 DE 19720 MD 817 CHURCHMANS CZZ

DHMH 17 Rev 1/2001

State Registrar

ORIGINIAL

32 Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Seitler Month Day **Physician** ph Sose 2008 Anthony 03 03 "/Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 74 Yrs 219-28-5456 Mar 18, 1933 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 □ No Carroll Maryland Westminster Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 USA 1051 Cherrytown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Korea 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Board Painter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip J. Seitler Grace R. Leitz ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Nickelson, daughter 1051 Cherrytown Road, Westminster, MD 21158 Department of Health Important: If item 27 any Injury or other tr. once. 20b. Place of Disposition (Name of Scoretty, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/5/2008 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one vause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning Learning Learning Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes has been signed to the second Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha perforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2XER/Outpatient 3 □ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year)

MJL BHIVA

> State Registrar

Martin Brito 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0064732

Carroll Hospital Center 200 memorial Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 6:40 Р м March 2008 James /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Serlin tome Derl VUMS: DG 8. Date of Birth (Month, Day, Year) 3-12-193 Birthplace (State or Foreign Country) 6. Sex ) 1 M M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Months Days Hours Min. 230 - 28 - 46 20 Usual Residence of Decedent Maryland Director 12-1931 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1 Yes 2 No by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2181 206 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🗖 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Spence, James Be permit. Pages 1 and 2 should be in Department of Health and Mental ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Spence 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XBurial 2 □Cremation 3 □Removal from State 4 ☐ Donation \5 ☐ Other (Specify) Cemeter 21. Signature of Funeral Service Licensee Salisbung Maybund 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and ched for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: After this certificate has been signed by the attendin funeral director, page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DIBTG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coastal Highway 1207 Nicholas Borochilia

DHMH 17 Rev 1/2001

State Registrar 32. Regist

MAR 0 6 2008

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 Year **Physician** A.M 08 INA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Norces Ursing Home 9. Birthplace Country) (State or Foreign 7. Age (In yes, last birthday) Year) **Funeral** Days Min. Months Hours 1 ☐ M 2 💢 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Nes 2 No Director 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 18 5 Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ۹ anu 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □ Removal from State Pocomoko 22. Name and Address of acility Barnic Smith 21. ature Funeral Service Licensee Funcial Home P.O. BOX331-Polomotic 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEAJE PARKINGON'S HOVANCED **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Case to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the SBS attending IF FFMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐ Unknown 9 Unknown signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 certificate has 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie U 314(2008 0062172 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ShARAD R SATYAL, MD 1604 MARKE 21851 MD POWMOKE GM ALANCKET ST 32. Pegistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAR 0 6 2008

08-01832 Steven Thomas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

even Thomas	1-	For State	State of	of Maryland /		ment of t		and Ment	ai Hygiei	Reg. f	20	08 09086
Physician	Re	egistrar . Decedent's Name (	(First, Middle,Last)						2. Dat	te of Death		3. Time of Death
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	4	a. Facility Name (if r		street and number)		45	. City, Tow <b>Princes</b>	n, or Location of s Anne	Death		Somerset	
	-	12235 Wink l		7. Age	e (In yrs. last	birthday)	If Under		24Hrs. 8. D	ate of Birth(	MM/DD/YYYY) 9. E	Birthplace (State or Foreign Country)
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and 2 Tealth item 2 Traus	ŀ	20a. Method of Disp	osition			ace of Dispos ematory or oth	ition (Name	e of cemetery,	Dat	te	20c. Location - Cit	y or Town, State
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)	Certifying Phys  Medical Examin	cian: To the best of er: On the basis of e	xamination a	ge, death occ ind/or investig	ation, in m	y opinion, death	occurred at the	ne time, date	and place, and du	e to the cause(s)
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	/Medic	al	John F. Utz. Sr.  4a. Facility Name (If not institution, give	e street and number)			4b. City. Town, or	Location of Death	3	5	County of Dea	
	Examin	er	Atlantic General				Berlin				Worcest	
	Funeral Director	1 1	5. Social Security Number 6. S		e (In yrs. last bin	<i>hday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi Month, D 7/22/1	rth av Year) 926	9. Bi	rthplace (State or Foreign PA
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	ter dea iteme	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh	ierican Indian, ite, etc.
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Sther then "natural", or Iteme 23a or 28a-f show after then "natural" or iteme 1 at an intermigration of the motified at an intermigration of the motified at all and the motifi	Be Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)			f)	n ig	Dia	intina	Company
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2	2 should and Men is marke	၉	19a. Informant's Name/Relationship (	Type, Print)	19b	Mailin	g Address (Street	and Number or Rur		ber, City	or Town, State,	Zip Code)
			John F. Utz. Jr.					Rd., Ber	rlin, M			
Baltimore.			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	20b. Place of cemeter	Dispo: y, cren	sition (Name of natory or other place	ce)	Date		ocation - City o	
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1926			23a 11. Enter the disease, or com- nock, or heart failure. List only	olications that caused one cause on each li	the death. Do r	not ente	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
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B.	daath e atter	Physician/M	in the past 12 months?	4☐Pregnant a	2 Fetal death time of death		Ectopic pregnancy Other (specify)				Month	Day Year
, O	at the by th	Phys	9 Unknown	9□ Unknown				W				
2. 2. ds.	The law requires that the daath certificate has been signed by the attending page 2 should be detached for use a	Ď	Part II. Other significant conditions of	contributing to death b	out not resulting in	the ur	iderlying cause giv	en in Part I.		Tobacco Yes 2		to the cause of death?  Probably 4 SUnknown
S 62	w req	Completed							24a. Wa		24b. Were	autopsy findings available
7 % 5	The la ate has page 2	mo							auto peri 1 ☐ Yes	opsy formed? 2 N	death	compiletion of cause of es 25 No
F   E	iclan: certifica	Bec	25. Was case referred to medical examiner?					26. Place of Deat				
2 - 76 Of C	Physic this ce at dire	၉	1 ☐ Yes 2 No		ent 2 ER/Ou	_		4   Nursing no				ecify)
	Jing P	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da		l'ime of njury	Wor	yat k? Yes 2 □ No	28d. Describe	how inju	ury occurred	
John Bivision	Attending Physician: r death. ector: After this certific. by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	e 290 Place of In	jury - At home, fa	rm, str	eet, factory, office	163 2 10				Rural Route Number,
口はる	al or A s after i Dire	Certification:	4 Homicide	building, ei	ic. (Specify)		,,		City or To	own, Stat	te)	
V	To the Hospital or within 24 hours after To the Funerel Direction completely filled in b	dical (		nysician: To the best niner: On the basis of and manner st	of examination an							
	To the within 2 To the complet	Me	29b. Signatore and title of certifier	1			29c. Licens	e number		29d. D	ate signed (Mo	nth, Day, Year)
	->=0		of van Eg	mond	MO		Do	56307		Man	ch 5, 2	ous
	BA 5+1		30. Name and address of person (who J. van Egmond MD,	completed cause of	death (Item 23a)	(Type,	Print) 9733 Healt	hnau Prim	e, Berlin	MD	ચા811	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature			J		·		
	Registr	ar	MAR 0 7 2	008	m H.	A	rade					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10d per fh g877 3-20-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $A^{\,\mathsf{M}}$ 14 2008 6:00 Ann Varner March Margaret /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 18032 Maugans Ave. Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Yrs. Dec. 11,1938 69 Pennsylvania Director 199-30-3261 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show at THYOS 2X No 28a-f sh notified Director MD Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? "natural", or Items 23a or 18032 Maugans Ave. 21740 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced Year or Dates: White item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill thent of Health and Mental Heart: If item 27 is marked oth Be Mary E. (Alt) Young William A. Young ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger P. Varner Sr. Husband 18032 Maugans Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages.
Department of H
Important: If ite
any Injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 3/17/2008 Hagerstown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician techi Concer disease or condition resulting in death) 4 cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss Unicease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the ass attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗆 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 1□ Yes 2□ No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🙀 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

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egistrar's Signature

Medred Comos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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O. Mico

nichael

31. Date filed (Month, Day, Year)

MAR 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 March **Physician** 9, 8:30 PM Vicere Florence /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Jefferson 3216 Sigler Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 23, 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 □ M 2√2 F Pennsylvania 85 181-18-6705 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Director Jefferson Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21755 USA 3216 Sigler Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: þ **¾**Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erma Ellen. Keesler Herzog Clutter Charles ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3216 Sigler Road, Jefferson, Md 21755 Barbara Wade/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 X Burial 2 ☐ Cremation 3/17/2008 Quantico Nat. Cem. Triangle, VA 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Rome, FA 21. Sign ature of F 1621 Opossumtown Pike, Frederick, MD r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Enter the disease, k or Heart failure. Li Immeditie Cause (Final disease or condition resulting in death) Du to (or as a consequence of): Lears Physician /Medical Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknow signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Residence Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death. 2 Accident death the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 ☐ Homicide filled in t within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD056590

State Registrar

DHMH 17 Rev 1/2001

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registraris Signature

167 31. Date filed (Month, Day, Year) 2008

State of Maryland / Department of Health and Mental Hygiene State Registra MFND#23a(a/b)perMF3/6/08, BMV, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician February 2/g 2008 Gregory David Wrice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perru Point
If Under 1 Year | If Under 24 Hrs.
Hours | Min. VA Maryland tealth Care Age (Tri yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2 ☐ F 578-68-5907 Director 57 May 22, 1950 Washington, DC une Mnown to Physician! Write, Gregory Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ms 23a or 28a-f shor r must be notified a 1√ Yes 2 No Director MD Prince Georges Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12311 Houndwood Way 20720 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Iten dical Examiner 11XIYes 2 □ No
If Yes, Give
Year or Dates: 1968–1970 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Management Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lilian Pendleton Dounveor မ David Gregory Wrice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Julia Wrice/Wife 12311 Houndwood Way Bowie Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/18/2008 | Arlington, Virginia Arlington National 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMcGuire Funeral Service, Inc. Indre 7400 Georgia Avenue,NW Washington,DC 20012 Approximate8 mo Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition as a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Coronary Artery Disease Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death Day 5 Other (specify) 2  $\square$  No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ No 1 Dunpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day , Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surderpal Sodhi, M.D realth Care System, Perry Point, MO 21902 VA Marylandt Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 06 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

MAR 0 4 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 **Physician** Barbara Ann Williams March 5:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6200 Columbine Ct. Prince George's Upper Marlboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 1 □ M 2 X F Days Hours 577-42-9571 73 5/15/1934 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6200 Columbine Ct. 20772 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Retail 18. Mother's Name (First, Middle, Maiden Surname) Mary Cline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Columbine Ct., Upper Marlboro, MD 20772 20c. Location - City or Town, State Brentwood, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 21X No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) l 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 0 5-050 orut 10 106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] § Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Honore Marianna Anderson 11:45 PM 19, 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Lutherville Baltimore County if Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) April 30, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 93 Months Min. 1 □ M 2 1 F Baltimore, MD. 212-09-3636 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Lutherville Directo Maryland Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 21093 300 W. Seminary Ave. United States Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: White 34 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) n/a Home Maker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H fitem 27 is marked oth Be Martin Leyko Bertha Kowalski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 238 E. Padonia Road Timonium, Maryland 21093 Mr. Paul B. Anderson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem.Gar. March 2008 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Iter 24, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Timonium, Maryland 4 □ Donation 5 □ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 21. Signature of Funeral Service License any 2325 York Road 21093 Timonium, Maryland Approximate Interval Between Onset and Death 23a. Part? Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Immediate Cause (Final **Physician** consisting sev years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, Ladin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and Due to (or as a consequence of) as the burial-Box 68760. physician certificate be Physician/Medical attending p for use as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a P.O. 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate Division or Vital 1□ Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ည After this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After Certification (Month, Day Year) Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month

strar's Signature

address of person who completed cause of death (Item 23)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 1734 PM 2008 ARMETTA DALVATORE MARCH 18 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SMHOL HOPKINS HOSP ITAL BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) BALTI MURE MD Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 30 219-10-080' Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Parkulle Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 Birmingham Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 11 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Johns 18. Nother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ALMETTA Parkville MD 20c. Location - City or Town, State HVENUE Birmingham ANE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Oak Lawn Cemeters 108 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name as didress of Facility Rd., Bit.; Evans Funial (napel - Crema BALTI MORE, MD 21234. 21. Signature of Funeral Service tionServices-Parkville 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ~9 DAYS SEPSIS **Physician** /Medical Due to (or as a consequence of): LIO DAYS Examiner CHOLANGITIS Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 15 DAYS GANGRENOUS law requires that the death certificate be executed CHOLEN CYSTITIS burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy for use 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To this 27. Manner of Leath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Injury Hospital or Attending 5 Pending investigation Natural thours after death.

-uneral Director: Af
ely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner started. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 18,2008 MALCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X 600 NOTH WOITE STEET Bartimore, maryland 21287 GALONZIK WANG ACQUELINE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

			For State Registrar	State of Mary	yland		artment of F ertificate of			ental Hy	giene Reg. No	2000	0 9	088
	Physici /Medi		1. Decedent's Name (First, Middle,	Jeanette	<u>.</u>	A]	ston			2. Date of De Month	eath Day	7. 2008		of Death
	Examir Funeral Director		4a. Facility Name (If not institution,  MAGIANA  5. Social Security Number  250-82-4116	reneral H	)Spi n yrs. la: 60	fal st birthday Yrs.	Ab City, Town, of Bull	mon	ee (	B. Date of Bir (Month, Da	th	Co	thplace (State	
	and ww		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City,	Town or L	ocation						10d. Inside	
	Maryl -f sho fied a	tor	MD	N/A	Ва	altin	nore							s 2 No
2	death with the Maryland ms 23a or 28a-f show Lmust be notified at	Funeral Director	10e. Street and Number 1105 N. Patte	rson Park A	lver	nue	10f. Zip Code 2121	.3				izen of What Co	ountry?	
1842	rurs after al", or ite Examine	by	11. Marital Status  1 Never Married Amarrie 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S.	. 13.	Was Decedent of In If Yes, specify Cub 1 ☐ Yes 2 No	fispanic O an, Mexica Specify		ify Yes or No ican, etc.)		14. Race - Ame Black, Whit		
1215-0	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical. once.	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4or 5+)			edent's Usual Occup e kind of work done DO NOT use retire		st of working	g		ind of Business Gener		spital
9 5	filed w Hygie other then		12th grade 17. Father's Name (First, Middle, L		I/Al	DIE	ary Arc		ner's Name (	First, Middle	, Maiden	Surname)		
lan	uld be Mental arked c	To Be	Roy Withersp	oon				Bea	ulah	Lads	on			
Mary	12 sho n and h ris ma	ľ	19a. Informant's Name/Relationsh				ing Address (Street						, ,	21202
P. S.	t and Health tem 27		Harold L. Als  20a. Method of Disposition				N. Pat osition (Name of matory or other pla		on Da			nue Ba		MD
OE OE	Pages nent of ant: If I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Linemoval Ilom State	_		emorial		3-22	-2008	R	andall	stown	, MD
Baltimore	permit. Departr Imports any Inji		21. Signature of Funeral Service L	icensee War	نه		2. Name and Addre			rch F enue	17		2120	2
			23a. Part1. Enter the disease, or shock, or heart failure. List of				ter the mode of dyi	ng, such a	s cardiac or	respiratory a	ırrest,		Approxim Interval B Onset an	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Septice	onseque									
	Examiner		Coguantially list conditions	Metast	ati	<u></u>	479 (	anc	er					
. 7	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onseque	ince of).								
68760, <	ficate be executed physician and is the burial-transit	dical Examiner	that initiated events resulting in death) Last	c	onseque	ence of):								
О. Вох	ath certi ttending or use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal	leath 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у				23d. Date of de Month	livery Day	Year
<u></u>	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditio	ns contributing to death but no	ot result	ing in the I	inderlying cause giv	en in Part	I.		tobacco ι Yes 2	use contribute to		death?
or Vital Records,		Completed								24a. Was auto perfe 1□ Yes		l prior to	utopsy finding completion of 2 \( \text{No}	s available cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		7/0 1 1/1	nt 3 DOA Oth	or.		Check only		_		
o.	iding Physician: th. After this certifica funeral director, p	n: To	27. Manner of Death	28a. Date of Injury	2	R/Outpatie 28b. Time ( Injury	III JU DOX	4 L N		e 5 Resi		6 □Other (Sperry occurred	ecify)	
sior	tendin eath. or: Afi the fur	catio	1	ation			M 1□	Yes 2□						
Division	after d Direct	Certification:	4 Homicide determine	28e. Place of injury - building, etc. (S	- At hom Specify)	ie, farm, si	reet, factory, office		28	If. Location ( City or To	Street an wn, State	nd Number or R e)	ural Route Nu	ımber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, I	Medical C	29a. Certifier 1 CertifyIng (Check only one) 2 Medical E	Physician: To the best of m examiner: On the basis of examiner stated	aminatio	ledge, dea on and/or i	th occurred at the tinvestigation, in my	me, date a	and place, areath occurred	nd due to the d at the time	cause(s , date and	) and manner a d place, and du	s stated. e to the cause	e(s)
	To th Withir To th	Me	29b. Signature and title of certifier	Jus	h	aD	29c. Licens	se number	568	/	29d. Da	te signed (Mon	th, Day, Year)	
	6		30. Name and address of person v	SU, M.	8,5	(Type	Mary!	and	Get	eneri	al	Hospi	tal	3
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 1	32 Registrar's	Signatu	re	este					•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

hysici /Media		1. Decedent's Name (First, Middle, Last George E. Adams					2. Date of Dear Month Februar	Day	3. Time of Death
xamir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	LDI GGI	4c. County	
		1305 Middleneck  5. Social Security Number 6. Se		to a triate to a	Salis	bury If Under 24 Hrs.		Wicon	
neral ector			M 2□F 7. Age (my/s	. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 22	Year) 1953	9. Birthplace (State or Fore Country) Maryland
E M		10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limi
#	cto	MD Wicomico	Sa	lisbury	,				1 □ Yes 2√N
I be n	Funeral Director	10e. Street and Number 1305 Middleneck D	rive		10f. Zip Code	21804	1	0g. Citizen of V USA	Vhat Country?
L	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race	e - American Indian,
event, the Medical Examiner must be nutitled at	b	1 X Never Married 2  Married 3  Widowed 4  Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Tes, specify Cuba	ап, мехісап, Ривпо Specify:	Hican, etc.)		k, White, etc. : white
Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give k	ent's Usual Occup and of work done O NOT use retired	durina most of work	ing	16b. Kind of Bu	siness/Industry
렴	Com	unk u	nk	pr	ep cook			food in	dustry
> •	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			Θ)
matic	To	Donald Raymond  19a. Informant's Name/Relationship (T)		10h Mailing	Addross (Ctross	Emma Ros			01-1- Ti- 0- d-1
other traumatic		Emma R. Baker/mot				and Number or Rura eck Drive			21804
y or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 ☒ Donation 5 □ Other (Specify)		Place of Disposi	And the second second				City or Town, State
eny injury or o		21. Signature of Euner II Service Lice is RO and 8	ade, Director			ss of Facility Omy Board MD 2120		Baltimo	re Street
the burial-transit	Iner	23a Part1. Enter the disease, or complete cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ne cause on each line.	18 + 4 5 + 5 quence of): Lu	in the mode of dying	-	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician/Medical Examiner	that initiated events resulting in death) Last	Due to (or as a consect.  3c. If yes, outcome of pregn. 1 Live birth 2 Fete 4 Pregnant at time of c	ancy eldeath 3□E	Ectopic pregnancy			23d. Date Mor	e of delivery nth Day Year
	۾	Part II. Other significant conditions con	ntributing to death but not res	sulting in the unc	derlying cause give	en in Part I.			ibute to the cause of death?  3 Probably 4 Unknow
	Completed						24a. Was ar autops perform 1 \( \text{Yes} \)	v 0	Vere autopsy findings availab rior to completion of cause of eath? ☐ Yes 2☐ No
2	o Be	25. Was case referred to medical examiner?	lospital:		3 DOA Othe	26. Place of Death			
	-	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 Li Nui Sirig Hoi	me 5 🗷 Reside 28d. Describe ho		
	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At his building, etc. (Specifical Control of the Control o	ome, farm, stree (y)	et, factory, office		28f. Location (Sti City or Town	reet and Number, State)	er or Rural Route Number.
and a second	Medical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death outline and/or inve	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and mai ite and place, a	nner as stated. Indidue to the cause(s)
	N I	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed	(Month, Day, Year)
completely filled in by the funer	_	, M			D6619				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1. 20<u>08</u> Month **Physician** March 14,  $A^{M}$ 4:10 Antoinette Aristidou /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Co. 7022 Belclare Road Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12,1938 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min Country) Maryland 1 M XX F 69 Director 212-34-3109 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at Dundalk Baltimore 1 ☐ Yes 2 No notified Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò be death with 7022 Belclare Road 21222 United States 23a must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status r than "natural", or iten the Medical Examiner Black, White, etc. 72 hours after 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 🔀 No 1 ☐ Yes 2 H No Baltimore, Maryland 21215-0036 White Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Mec any Injury or other traumatic event, the Mec once." Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Frank Just Sophia Theresa ၉ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gust John Aristidou 7022 Belclare Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3/19/2008 1X Burial\_ 2 □ Cremation 3 ☐Removal from St Owings Mills, MD Other (Specify) 4 □ Donation rison Forest V.A. Cem. 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventralar Wins /Medical Due to (or as a consequence of): Examiner b. Hypertensuic Amerosclevetri Curlisvarcilar Diseve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. g□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes certificate 1∐ Yes 2□ No Physiclan: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I hours after death.

Uneral Director: A

ely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ئے۔ the Funeral Dire. اکات کاری 4 Homicide 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I Kersent aus meuran 14, 2008 D39leleo W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Point Rd. Baltimere 31. Date filed (Month, Day, Year) 3 Registrar's Signature State MAR 21 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** March 17, Joseph Ayd Jr. 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lorien Assisted Living Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F 1920 Maryland 14. 212-12-5002 87 October Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Baltimore Timonium 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21093 USA 12246 Roundwood Road Unit 307 ms 23a items Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natu vent, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physician Psychiatry Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Mental item 27 is marked o other traumatic eve Frank Joseph Avd. Sr. Sadie Baker မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unit 307 Timonium, Md. 21093 12246 Roundwood Road Mrs. Rita Anne Ayd (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State John Long Green Cem. 3/24/2008 Hydes Maryland 4 ☐ Donation 5 ☐ Other (Specify) Towson, Md. 21234 22. Name and Address of Facility 21. Signature of Tymeral Service L Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eca R disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) U, FRANK ivision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autop-performe 21 certificate ha 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Jeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1241 30. Name and address of person who completed cause of death taulkner MD 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINIAL

08-02123
Laietta Brooks

ajetta Brooks		1- For State	/ Department of H Certificate of D			200	8 0909
Physicia	in/	1. Decedent's Name (First, Middle,Last)	0		2. Date of Death	n No. Day Year	3. Time of Death
Medical Exami	ner	LAJETTA		OKS	March 16, 2	4c. County of Death	0846 hrs
		4a. Facility Name (if not institution, give street and number Sinai Hospital		City, Town, or Location of Deat saltimore	n	N/	Δ
Funeral		5. Social Security Number 6. Sex 7. Ag	· · · · · · · · · · · · · · · · · · ·	f Under 1 Year If Under 24Hr			hplace (State or
Director		215-84-9716 1_M 2×F	45 Yrs.	Months Days Hours Min	NOV. IC	0.1962 Col	Intry) MARVLAND
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location			7	10d. Inside City Limits
* .	۲	MARYLAND BALTIMORE	()	WINGS	MILL	S	1 Yes 2 No
Maryla 28a-f:	Director	10e. Street and Number	# 10	of. Zip Code	10	g. Citizen of What Cour	try?
ith the Maryland 23a or 28a-f sh		4407 SHADY BROOK	LA APTC 201	21117		45	A.
ath wi	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces	? If Yes, s	ecedent of Hispanic Origin?(S specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	can Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1 Ye	s 2 X No specify:		Specify: BL	ACK
hours	pa pa	15. Decedent's Education (Specify only highest grade co	during most of	Jsual Occupation (Give kind of of working life. DO NOT use re		16b. Kind of Business/I	ndustry
336 thin 72 hours a re. than "natura edical Examir	Completed	Elementary/Secondary (0-12) College (1-4 or	0	STER NURS	· ·	SOONGELLA	STATE HOSPITAL
5-00 led wit Hygien other the Ma		17. Father's Name (First, Middle, Last)	1 1/4651	18.Mother's Nam	e (First, Middle, M	aiden Surname)	JAIC NOTHIE
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	LEROV  19a. Informant's Nam-Relationship (Type, Print)	BROOKS	DEL Idress (Street and Number or	ORES	oor City or Town State	MALL
ages I and 2 shount of Health and Nt. If item 27 is not other traumatic	٩	DOLORES WADE (MOTH		ARLINGTON AV	2.50	1001 BALTO.	MN. 212 17
re, N Health	- 1	20a. Method of Disposition  1 Removal from S	20b. Place of Disposition	(Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, Definit. Pages I an Department of Her Important: If ite		4 Donation 5 Other Specify:	ABBUTUS	CEMETERI 03			
Baltim permit. Pag Department Important: injury or o		21. Signature of Funerat Service Licenses	22. Name	e and Address of Facility	ROWNO	R. FUNER	AL HOME
Physician	-	3a. Part Denter the disease, or complications that caused	the death. Do not enter the m	node of dying, such as cardiac	or respiratory arre		Approximate Interval
/Medical	9	✓ fail⊌ré. List only one cause on each line. Immediate Cause (Final disease a. Heroin Into	exication and coca	aine use			Between Onset and Death
Xuiiiii Çi		or condition resulting in death)  Due to (or as a cons	equence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	equence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a cons	equence of):				
executed an and al - transit	a E	d.					
), be es	edical		27,28a-f per ME g	g877 3/26/08 amh		Lood Bate of dell' in	
ox 68760 eath certificate beath certificate beath cuse as the business as the business and the business and the business and the business and busine	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outco	me of pregnancy  2 Fetal of	death 3 Ectopic pregr	nancy	23d. Date of delivery	Day Year
Box 6876 death certificate the attending phy	Physician/M	1 Yes 2 No 9 Unknown g Unknown	t time of death 5 Other	(Specify)		0	
9 + 9	Ph		th but not resulting in the unde	erlying cause given in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
S, P.C.	ed by				1 Yes		pably 4 V Unknown
ords, aw requir as been s	plet	-			24a. Was a autops	sy prior to o	topsy findings available completion of cause of
tal Rec	Completed				1 ✔ Yes 2		es 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaid.	a	25. Was case referred to medical examiner?  Hospital: 1 Input:	ent 2 ER/Outpatient 3	26.Place of Death (Chec		Residence 6 Othe	<del></del>
ion of V tending Phy eath. or: After th	2	27. Manner of Death 28a. Date of Inj	ury 28b. Time of Injur		28d. Describe h	ow injury occurred	
sion trendi death. ctor: /	atio	2 Accident Sending Investigation Found 3/1	6/08 found 8:00a		Unknown		
Divisi ospital or Ati hours after d uneral Direct y filled in by	Certification:	Suicide 6 A Could not be	njury - At home, farm, street, fa	actory, office building, etc.	or Town, St	ate) 4171 Wakef	ield Road
Division to the Hospital or At Within 24 hours after do the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of n				e(s) and manner as stat	
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated	mination and/or investigation,		at the time, date a		
	Σ	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mo March 17, 2008	nth, Day,Year)
	-	30. Name and address of person who completed cause of	death (Item 23a)				
		Donna M. Vincenti, MD Assistant Medi		enn Street, Baltimore, I	MD 21201		
St Regist		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature				
DHMH 17 Rev 1/20	_		ORIGINAL	<i>y</i>			
0.0145.0000							

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Ma	aryland		irtment of H <i>tificate of L</i>		d Mental Hy	giene Reg. No.	008	09093
	Dhuaisi	- >	Decedent's Name (First, Middle)	, Last)					2. Date of De		Year	3. Time of Death
Sec.	Physici /Medic	_	Eva M.	Beals					March	18	2008	<u> </u>
>	Examin	er	4a. Facility Name (If not Institution, Pleasant View	give street and number)	Home		4b. City, Town, or		M		nty of Death	
/-	Funeral	*	4101 Old Nati	6. Sex 7. Age	e (In yrs. la	st birthday)	Moun +	If Under 24 F	rs. 8 Date of Bir	th	9. Birth	nplace (State or Foreign
AWA	Director		217-16-7468	1□M 2 <b>X</b> F 88	}	Yrs.	Months Days	Hours M	Nov 15	1919	MĎ	untry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Maryl -f sho fied a	tor	MD Baltim	ore	Ba1	Ltimor	e					1 □ Yes 2 X No
	th the or 28a e notifi	lirec	10e. Street and Number		1		10f. Zip Code			10g. Citizen	of What Co	untry?
	ath wir	Funeral Director	931 Kent Avenu				21228			USA		
	er des items ner m	nue	11. Marital Status 1 ☐ Never Married 2 ☐ XMarrie	12. Was Decedent I Armed Forces?		3. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? an, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	)-   14. F	Race - Amer Black, White	rican Indian, e, etc.
38	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 □ N If Yes, Give X Year or Dates:	10		∐Yes 2∐XNo	Specify:		Spe	cify: wh	ite
21215-0036	72 hou natura fical E	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	lent's Usual Occup	ation during most of	workina	16b. Kind of	Business/I	Industry
2	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	oo not use retired emaker	()		domes	stic	
ς σ	filed v Hygie Ither t	ပ္ပ	17. Father's Name (First, Middle, I	 Last)		110111	emaker	18. Mother's I	Name (First, Middle	, Maiden Surn	name)	
an	ild be lental rked o	To Be	Constant Coonan					Ruth S	hanaman		·	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Carol Malinowsk						Rd., Wood			
e,	1 and Health em 27 ther t		20a. Method of Disposition				sition (Name of	TCI ICK	Date Date	20c. Locatio		
Baltimore,	ages ent of l t: If it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ce	metery, crer	natory or other plac n Memoria				•	lle, MD
alti.	mit. Fortan		21. Signature of Funeral Service I	Licensep	101.00	22	. Name and Addres	ss of Facility <b>H</b> ;	aight Fun	eral Ho	ome &	
Ä	De and		▶ (Jarge Haigh	4 Herbert		P	.O. Box 1	.95 Syk	esville,	MD 2178	34	
			23a. Part1. Enter the disease, or shock, or heart fallure. List		_				diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
9	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			PNEUMO	MIA				Two weeks
	Examiner			Due to (or as	a conseque	ence or):						
	7 / 5	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):						
	ecuted and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
68760,	ificate be executed g physician and and as the burial-transit	a E		Due to (or as	a conseque	ence or,						
	ifficate g phys as the	edical		d								
Box	th cer tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnan		Ectopic pregnancy	,			Date of deli	
о Ш	res that the death certi igned by the attending be detached for use a	Physician/M	in the past 12 m/6nths? 1 □ Yes 2 ଐ No 9 □ Unknown	4□Pregnant at 9□Unknown	t time of de	ath 5□	Other (specify)				Month	Day Year
, 0.	that the		Part II. Other significant condition	ns contributing to death b	ut not resul	ting in the ur	nderlying cause give	en in Part I.	23e. Did 1	tobacco use c	ontribute to	the cause of death?
rds	w requires been sigr should be	ed by	SENILE	DEMENTIA	~				_ 10	Yes 2 No	3 □ Pr	obably 4 □Unknown
eco	The law requires that the death certi te has been signed by the attending rage 2 should be detached for use a	Completed	HYPERTE	NSIGH					24a. Was	psv	prior to c	topsy findings available completion of cause of
<u>=</u>		Con	OSTED ART	HRITIS						ormed2 2 No	death? 1 ☐ Yes	
Zi.	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:		D/Outnotion	t 3 DOA Oth	or:	Death (Check only			
0	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju	ıry :	28b. Time of			ng Home 5 ☐ Resi 28d. Describe			city)
ion	endingath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	y rear)	Injury		Yes 2 □ No				
Division or Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi				eet, factory, office		28f. Location ( City or To	Street and Nu wn, State)	mber or Ru	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, is			g Physician: To the best								
	the Ho in 24 h the Fu	Medical	(Check only 2 Medical I one)	Examiner: On the basis of and manner sta		on and/or in	vestigation, in my o	pinion, death o	occurred at the time	, date and plac	e, and due	e to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier	Colomb	2	-	29c. Licens	3046	9	29d. Date sig	ned (Monti	h, Day, Year) 2008
)	0		20 Name and address of some	who completed cause of the	path /Itam	23a) /Tr	Print)		,	1201	111	
	3		30. Name and address of person (850, Columb					olum	BiA, A	10 -21	545	
ľ	Sta Registr		31. Date filed (Month, Day, Year)	2008 Registra	ar's Signati	ure	de la					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 19 Year Month **Physician** orum well 1605 Soyal 2008 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. UNIVERSITY Social Security Number . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1XM 2□F Maryland Director 213-30-8645 Feb. 6, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4438 Purple Martins Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 Business Owner Fuel Company is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brumwe11 Schmidt Grace Anna ပ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages I .... Department of Health and Important: If item 27 is ...iniury or other tra 389 Edgewater Road Pasadena, MD Mrs. Bonnie Brumwell Hoyas 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State March 24, 2008 4 □ Donation 5 □ Other (Specify) Mt. Caramel Cemetery Pasadena, MD 22. Name and Address of Facility Singleton Funeral & Cremation Svs. 1 2nd Avenue, S.W. Glen Burnie, MD 21061 21. Statuture of Funeral Service Licensee Mov918 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEART DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each or only in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ ₩0 24a Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 20 No 1/ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760. physician attending for use as signed by the a has certificate Hospital or Attending Physician: director, after death | Director: / d in by the f To the Hospius after within 24 hours after To the Funeral Dir

with 1

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Certification: To 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29c. License number

32. Registrar's Signature

State Registrar 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

March 19, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Bathmore, MD 2120)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day 17. 2008 Physician 3,20 Patten Bailey Ruth MAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pikesville Baltimore Jewish Convalescent Home If Under 1 Year If Under 24 Hrs. And Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06 30 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F 215-10-7581 92 Director 15 GA Usual Residence of Decedent the Maryland show 10h County 10c. City Town or Location 10d. Inside City Limits 7 is marked other then "netural", or items 23e or 28e-f shov treumatic event, the Modical Examinar must be notified at Baltimore Pikesville 1 ☐ Yes 2X No Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 6 Pomona North #2 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Heath and Mental Hygiene. Int: If item 27 is marked other then "netural; or ite Yes 2 ANo 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Be Completed by 3€ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembler Telephone Equip. Western Electric 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Patten Classie Browner 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley R. Bailey Brice 6 Pomona North #2, Baltimore, Md othert Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ö permit. Page Dep: rtment of Impcrtent: if any njury or once. Arbutus Memorial 3/22/08 Arbutus, Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) do Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) lhe Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 121 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has 2□ No 1 ☐ Yes 20 1 Tyes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 9 1 🗌 Yes 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending death. investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel ( Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier MARCH. 17. 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U 2434 Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar Arous.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of He <i>rtificate of D</i> e			ene g. No. 200	0 00006
	Division		Decedent's Name (First, Middle,	Last)	· - ·			2. Date of Death	1 6 0 0	3. Time of Death
. *	Physicia /Medic		Louise			Brown		Month O3	15 200	3.335.
	Examin	er	4a. Facility Name (If not institution, Manor Care Nu		9	4b. City, Town, or Lo Caton	sville		4c. County of De	imore
ine	Funeral Director		212-40-2189	6. Sex 7. Age 1	e (In yrs. last birthday) 86 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07 01	<sup>Year)</sup> 21 9. B	sirthplace (State or Foreign Country) Md
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f sho	ctor	MD NA		Baltin	nore				1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	
	eath w	Funeral Director	1726 North Pu	12. Was Decedent E		2121		ecify Yes or No-	U . S	◆ A    ◆ merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	1 □ Never Married 2 □ Marrie  Wildowed 4 □ Divorced	Armed Forces?	No I	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	Mexican, Puerto  Specify:	Rican, etc.)	Black, WI	
ည်	72 hou natura lical E	sted	15. Decedent's	s Education t grade completed)	16a. Dece	dent's Usual Occupati	on ring most of work	ina 1	6b. Kind of Busines	ss/Industry
121	within sne. than "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5	i+)	kind of work done due DO NOT use retired)  ousewife			Hom	e
d 2	filed v Hygie other 1	Be Co	17. Father's Name (First, Middle, L			1		(First, Middle, N		
/lan	uld be Mental rrked rtic ev	To B	Clarence Broo	oks		L	eona G	arrison	<b>1</b>	
Maryland 21215-0036	nd 2 sho lith and 27 is ma r traums		19a. Informant's Name/Relationsh  Eugene Brown			ng Address (Street an				
Baltimore,	es 1 and 2 of Health a fitem 27 is r other trau	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)		Date 2	20c. Location - City	or Town, State
<u>E</u>	Page ment tant: It		4 Donation 5 ☐ Other (Sp	ecify)		ar Hill		4/08	Baltimo	re, Md
Ball	permit Depart Import any In	0 9	21. Sinbatul of Funeral Service L	5. X	ec 4:	2. Name and Address arch F/H 300 Wabas	sh Ave,			21215
l,			23a. Part1. Enter the disease, or o shock, or heart tellure. List of	complications that caused only one cause on each lir	the death. Do not en	ter the mode of dying,	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
9	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Bue to (or as	a consuence of):	that h	pro	ron		10
	Examiner			Due to (or as	Stro	ke	1			Ino.
7	D its	Iner	Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):	s selesi	0	1 -		101-
<i>y</i>	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):	22 clus	tin_	asia	u	logos
68760,	ficate be executed physician and sthe burial-transit	dical E		d						
	ertifical ing phy e as th	w	IF FEMALE:							
Box	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome  1 Live birth  4 Pregnant at	2 ☐ Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of o Month	delivery Day Year
P.O.	the de	nysic	1 ☐ Yes 2 TNo 9 ☐ Unknown	9□Unknown	unie or deaur - St					
	es gu	þ	Part II. Other significant condition	ns contributing to death be	ut not resulting in the u	inderlying cause given	in Part I.	23e. Did tob		e to the cause of death?  Probably 4 □Unknown
Records,	law requir as been si 2 should	Completed						24a. Was ar	y prior	autopsy findings available to completion of cause of
۳ چ		Соп						perform 1 Yes 2	ned? death 1 □ Y	
or Vital	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 2 100	Hospital:	ent 2 ☐ ER/Outpatie	Othor	/	h (Check only one	nce 6 □Other (S	'maniful
יסר	ig Phy ter this neral d	n: To	27. Mann of Death	28a. Date of Inju	ry 28b. Time o				w injury occurred	респу
Sior	Attending r death. ector: After by the funer	atio	atural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no	ation	, rear, injury		es 2□No			
Division	l or Att after d Direct I in by	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (St City or Town		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.		(Check only 2 \ Medical E	Physician: To the best of the basis of the b	f examination and/or it	th occurred at the time	e, date and place, nion, death occur	and due to the ca	ause(s) and manner ate and place, and o	r as stated. due to the cause(s)
	thin 24 the F	Medical	one) 29b. Signature and title of certifier	and manner sta		29c. License			9d. Date signed (Mo	
ì	Z Wi		b and and or solution	1.	n land.	- 00	207	19	3/18	108
,	1D		30. Name and address of person v	vho completed cause of	eath (Item 23a) (Type,	Print)	1	6	110	2/228
	11/4		moraling	D. A.16	verre	my 5/1	ba, R	Ming 1	d Bn	140 hol
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Hegistra	ars Signature	me			•	

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		1 - State of Management of Man	arylanc		irtment of H tificate of I	lealth and M Death		ene 1. No. 2 A A S	09097
Physicia	an	1. Decedent's Name (First, Middle, Last)		DUTT			2. Date of Death Month	Day Year	3. Time of Death
/Medic Examin	al	RICHARD  4a. Facility Name (If not institution, give street and number)		BUTT	4b. City, Town, or	Location of Death	March	17 200 8 4c. County of Deat	
LXaiiiii	G1	Sinai Hospital			.0 -	more	L 0 D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	N/A	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Ag Usual Residence of Decedent	e (In yrs. Ia 67	st birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 07/06/19	(ear) PIS	hplace (State or Foreign TRUCT OF UMBIA
ryland how lat		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 No
the Ma 28a-f s	ecto	MD BALTIMORE  10e. Street and Number		BAL	TIMORE 10f. Zip Code		100	g. Citizen of What Co	
th with 23a or 1st be	al Di	2500 SUMMERSON ROAD				21209		USA	
filed within 72 hours after death with the Maryland Hygiene. Hygiene, Hygiene, Hygiene, wither than "natural"; or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces? 1 NY S 2 1f Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I □ Yes 2 1 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: WH	e, etc.
be filed within 72 ho ital Hygiene. Id other than "natur event, the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or to 1)	5+)	(Give life. L	lent's Usual Occup kind of work done of OO NOT use retired PROFESS	during most of work t)		6b. Kind of Business	
e filed all Hygir	Be Co	17. Father's Name (First, Middle, Last)			V TROI ESS	18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
d Ments narked natic e	2	SOLOMON	BUT		a Address (Street	HELE		GLASN City or Town, State, 2	
and 2 sh alth and 27 Is n		19a. Informant's Name/Relationship (Type. Print)  ARLENE BUTT / WIFE			,	ON ROAD,	-		209
ges 1 a t of He if item or othe		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Removal from State	ce	ace of Dispo metery, crer	sition (Name of natory or other plac	ce)	Date 2	0c. Location - City or	
permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than "n any injury or other traumatic event, the Medionce.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	BEI	H TFII	_UH t. Name and Addre			ALTIMORE, ON & BROS	
2 2 2 E 8 8		Matt Cerr	d the death						, MD 21208 Approximate
Physician		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition	-			Embol.		51,	Interval Between Onset and Death
/Medical Examiner		resulting in death)  Due to (or as	a consequ	ence of):	7	,=,,,,			
7 pe dis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequ	ence of):					
execute an and rial-tran	Examiner	that initiated events resulting in death) Last C	a consequ	ence of):					
icate be physici s the bu	dical	d		-					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗆 Fetal	death 3□	Ectopic pregnancy Other <i>(specify)</i>	′		23d. Date of de Month	livery Day Year
s that th	by Phy	Part II. Other significant conditions contributing to death b	out not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
requires							1 ☐ Yes	2 No 3 P	robably 4 Hunknown
he law e has b	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
ctor, pe	Be Co	25. Was case referred to medical examiner?					th (Check only one		
Physic r this or	٦ م	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati 27. Manner of Death 28a. Date of Inji	ıry	R/Outpatier 28b. Time o			ome 5 Resider	nce 6 Other (Spe	ecify)
ath. or: Afte	ation	1 ☑ Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y Year)	Injury		k? Yes 2 □ No			
I or Atter de after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of in building, e	iury - At hor tc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,
ne Hospita n 24 hours ne Funera bletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner st	of examinati	vledge, deat ion and/or in	n occurred at the tivestigation, in my	me, date and place, opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. le to the cause(s)
To t To t	M	29b. Signature and title of certifier	- m	0.	29c. Licens			d. Date signed (Mon March, 1	
O		30. Name and Address of person who completed cause of a Dr Patrick McGinley	death (item	23a) (Type,	Print)	lundaro	Ave 1	Baltimore	7,2008 , MO 21215
Sta		31. Date filed (Month, Day, Year) 32. Regist	rar's Signat	ure					7
Registr OHMH 17 Rev 1/20		MAR 2 1 2008	and the same	S. A	parki				
A AVIII II NEV 1/20	JU 1				GINAL				

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Warylank	-		of Dea			Reg. No			
F	Dhysisi		1. Decedent's Name (First, Middle, Las	•					2. Date of De Month	ath Da	y Year	3. Time o	f Death
	Physicia /Medic		Paul	Dow Berggre	n				March	19	, 2008	2:40	РМ
	Examin	er	4a. Facility Name (If not institution, give			4b. City, T	own, or Loca			4c.	. County of Deatl		
			Suburban Hospital  5. Social Security Number 6. Se		ast hirthday)	If Under 1	Beth	esda nder 24 Hrs.	8. Date of Birt	th	Montgo		or Foreign
	Funeral Director			XM 2□F 76	Yrs.		Days Ho		May 12	y, Year) 19	31 Iow	nplace (State untry) 1a	oi roreign
	/land ow at		10a. State 10b. County	10c. City	, Town or Lo	ocation						10d. Inside C	ity Limits
	A-f sh	tor	Maryland Montgon	nery ]	Bethes	da						1 □Yes	2 <b>∑</b> No
	or 28	Jire	10e. Street and Number			10f. Zip (				10g. Cit	tizen of What Co	untry?	
	ath w	rai	9619 Bellevue Dri				208				ited St		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 ☐ No 195  If Yes, Give Year or Dates: 1974	4-	Was Decede If Yes, speci		ic Origin? (Sp exican, Puerto ecify:	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White Specify: W		
ה ה	72 h 'natu dical	etec	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	16a. Dece (Give	dent's Usual kind of work	Occupation done during	most of work	ring	16b. K	ind of Business/I	ndustry	
7	vithin sne. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use				Uni	ted Stat	tes Nav	JV
V	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	JT	Havy	Comme		Mother's Nam	e (First, Middle,				
<u></u>	d be sental	To Be	Paul David Bergg	ren				Hazel :					
	shoul nd Me mari	۲	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (				er, City o	or Town, State, Z	ip Code)	
₹	alth a 27 is 27 is		Deborah Berggren /	/ Wife	9619	Belle	vue Dr	ive, B	ethesda	, Ma	ryland	20814	
֖֖֖֖֖֖֖֓֞֝֝֝֝֝֝֝ בו	Pages 1 and the pages 1 and th		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Monte	ace of Dispo emetery, cre	osition (Name matory or oth		Marc	Date h 21,	20c. Le	ocation - City or thesda,	Town, State	nd
Dall	permit. Departrr Importa any inju		21. Signature of Funeral Service Licen		0.5 RC	Name and	Address of Fumphr	ey Funer	ral Home/	Beth	esda-Chevy 1 <i>a</i> nd 2081	Chase,	
Κ.	J. Famel		23a. Part1. Intrit disease, or compshock of heart failure. List only of immediate Cause (Final	one cause on each line.	. Do not en	ter the mode	of dying, suc				121 KI 2001	Approxima Interval Be Onset and	te tween Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		y Dise	ease					28 Yea	ars
		er	Sequentially list conditions, if any, leading to immediate	b	ence of):								
	ertificate be executed ing physician and eas the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,								
ב ב	exec an and rial-tra		resulting in death) Last	Due to (or as a consequ	ence of):								
2	ate be nysicia ne bu	ical	•	d									
5	ng ph	Med	IF FEMALE:						-	T			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	⊒Ectopic pre ⊒ Other (spe		-			23d. Date of deli Month		Year
, L	s that ned by deta		Part II. Other significant conditions of	ontributing to death but not resu	Iting in the u	nderlying car	use given in F	Part I.	23e. Did t	obacco	use contribute to	the cause of	death?
3	quires en sigi uld be	ed by							1 🗆 '	Yes 2	□ No 3□ Pro	obably 4 🛚	Unknown
מטטנו	he law re e has bee tge 2 sho	Completed							24a. Was autor perfo		24b. Were au prior to death?	ompletion of	available cause of
2	an: T tificat tor, pa	മ	25. Was case referred to medical			_	26. I	Place of Deat	1 Yes h (Check only o		1 □ Yes	2□ No	
>	ysicl is cer direc	OB	examiner? 1 ☐ Yes 2🌠 No	Hospital: 1 X Inpatient 2 ☐ 8	ER/Outpatie	nt 3 DOA	Other:				6 ☐Other (Spec	ify)	
	nding Ph tth. r: After th e funeral	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	3c. Injury at Work? 1 ☐ Yes	2 No	28d. Describe I	how inju	ry occurred		
	al or Atte s after dea al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, sti	reet, factory,	office		28f. Location (8 City or Tox	Street ar vn, State	nd Number or Ru e)	ral Route Nur	nber,
	ne Hospil n 24 hour ne Funer	Medical (	29a. Certifier (Check only one)  1 ★ Certifying Physics 2 ★ Medical Examples	ysician: To the best of my know niner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred a evestigation,	at the time, da in my opinior	ate and place, n, death occur	and due to the rred at the time,	cause(s date an	and manner as d place, and due	stated. to the cause(	(s)
	To the To	ž	29b. Signature and title of certifier	//			License num				ite signed (Month		
	VI		De K	M.D	, (		D57032			Ma	rch 19,	2008	
	2011		30. Name and address of person who										
	J		Gregory Kegham Kur	mkumian, M.D.	6410	Rock1	edge D	rive,	Suite 2	00,	Bethesd	a, MD :	20817
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2 1 2003	32. Registrar's Signal	ANNA	21							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland		rtment of F tificate of		Mental Hy	giene Reg. No.	2000	1 19199	
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Do Month	eath Day	y Year	3. Time of Death	-
No.	/Medic	al	4a. Facility Name (If not institution, give	Street and number)	-m/c		4b. City, Town, o	r Location of Dea	MARC		County of Deat	8 16:39 PM	_
	Funeral Director		5. Social Security Number 6. Sec 215-48-9861 1	K XM 2□F 7. Age	Medicular (In yrs. last 57	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bi	rth aw, Year)	795h Co	hplace (State or Foreign untry) Py land	_
	/land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loca	ation					10d. Inside City Limits	_
	ne Mar 8a-f sh otified	Director	Maryland Baltim	ore	Dun	idalk						1 □ Yes 2 □ No	_
	3a or 2		10e. Street and Number  1304 Blakewood Cour.	n+			10f. Zip Code 2122	22		-	izen of What Co $S$ . $A$ .	ountry?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:				dispanic Origin? (san, Mexican, Pue	Specify Yes or Norto Rican, etc.)		14. Race - Ame Black, White Specity: Wha	e, etc.	_
21215-0036	within 72 hou iene. • than "natura ihe Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+		(Give k. life. Di	ent's Usual Occup ind of work done O NOT use retired	during most of wo d)	orking		ind of Business/	Industry  PS Office	
nd 2	be filed tal Hygi d other event, tl	To Be Co	17. Father's Name (First, Middle, Last)			Du	perocsor	18. Mother's Na	me (First, Middle			es office	-
Maryland	should I and Men s marke umatic	၉	Talmadge Balla  19a. Informant's Name/Relationship (Ty			19b. Mailing	Address (Street	Elsie and Number or F	COX		or Town State 2	Zin Code)	_
	and 2 sl ealth an n 27 is r		Patricia Ballance,	,		1304	Blakewoo	od Court	Dundal				
Baltimore,	Pages 1 nent of He ant: If Iter ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cem	etery, crem	ition (Name of atory or other plac Service	ce) Corp. 3/	Date /21/08		ocation - City or USON • Mc		
Balt	permit. Page Department Important: II any injury o		21. Signature of Funeral Service Licens	» (a.	,			ess of Facility 1				undalk, Inc. 21222	
68760°C	Physician and hysician and physician and physician and street principle.	edical Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequen	RRE nce of):		ng, such as cardia	ic or respiratory a	arrest,		Approximate Interval Between Onset and Death	_
P.O. Box 68	death certi e attending id for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal de	eath 3□E	Ectopic pregnanc Other (specify)	у			23d. Date of del Month	ivery Day Year	
	The law requires that the te has been signed by th vage 2 should be detache	þ	Part II. Other significant conditions con		t not resultin		derlying cause glv	en in Part I.				o the cause of death?	
Division or Vital Records,		Completed							24a. Was auto perf 1 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of	
Z	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital:	nt 2∏ER	/Outpatient	3□ DOA Oth	or:	ath <i>(Ch</i> eck o <i>nly</i> Home 5□ Res		6 □Other (Spe	cifv)	
ion o	nding Ph ath. r: After th e funeral		27. Manner of Death  1 Natural  2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day		Bb. Time of Injury	28c. Injui Wor M 1		28d. Describe			,	Ī
Divis	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.		e, farm, stree	et, factory, office		28f. Location City or To	Street and who, State	d Number or Ru )	ural Route Number,	
	e Hospi 24 hour e Funer etely fill	Medical	29a. Certifier (Check only one)	sician: To the best of ner: On the basis of and manner stat	examination	edge, death n and/or inve	occurred at the tilestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as d place, and due	s stated. e to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier	7/			29c. Licens	e number		29d. Da	te signed (Mont	h, Day, Year)	
		-	30. Name and address of person who do	M0	oth (Non- Co	20) /T D	DOO	S757	+	MAR	CH 15,	2008	
_	10		Leah Wolfe, MD	4940 Eas	stem	Ace		timare,	HO ala	PER	<u> </u>		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	COSAL		)		•			

			For State Registrar	State	of Marylar	nd / Depart <i>Certi</i>	ment of H		Mental Hy	giene Reg. Na	$Z \cup U \cup C$	0	9100
Ε,	Disconist		1. Decedent's Name (First, Middle	, Last)					2. Date of De	eath Da	y Yea		ime of Death
	Physicia /Medic		ANITA	ρ.	BLAN	KENSI	414		MARCH			67 9 / A.	201 PM
	Examin	ıer	4a. Facility Name (If not institution	_			b. City, Town, or	Location of Dea	th	40	. County of De	ath	
		4,3	JOHNS HOPKINS				f Under 1 Year	AUT M			N/A		
	Funeral Director		5. Social Security Number 218–36–2608	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 68		Months Days	Hours Min				Country)	State or Foreign
146	Director		Usual Residence of Decedent						Dec. 24	19.	39   <u>M</u> a	rylan	id
ylanc	show ed at		10a. State 10b. County		10c. Ci	ty, Town or Locat	ion					10d. ins	side City Limits
Mar	a-f sl iffied	ctor	MD Balt	imore		Dundalk						1[	□Yes 2∏No
death with the Maryland	or 28 e no	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What (	Country?	
ath w	23a ust b		7801 Penisula			t.413	21222				S.A.		
er de	tems ner m	Funeral	11. Marital Status	Armed	ecedent Ever in U Forces?	J.S. 13. Wa	s Decedent of H es, specify Cuba	ispanic Origin? (S an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	)-	<ol> <li>Race - An Black, Wh</li> </ol>		ian,
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and A	al Hy lothe vent,	Be C	17. Father's Name (First, Middle, I	.ast)				18. Mother's Na	me (First, Middle	, Maider	Surname)		
aryland	and Mental Hygiene. Is marked other than aumatic event, the M	흔	unknown	Fallon				Ann		ırka			
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and S	ealth m 27 her tr		Jeanette Campbe	Ll/Daugn									
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Dermi Dermi	Department of Important: If I any injury or once.		21. Signature of Funeral Service I		_	22. N	lame and Addres	ss of Facility $D u$	da-Ruck	F.H.	of Du	ndalk	, Inc.
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			shock, or heart failure. List	only one cause or	each line.	in. Do not enter				irrest,		Interv	oximate val Between t and Death
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ath cer	ttendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome pf pregn e birth 2 🗆 Fet	aideath 3⊟Eo	ctopic pregnancy	,		4	23d. Date of o	lelivery Day	Year
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hat th	been signed by the attending p should be detached for use as	Ph	Part II. Other significant conditio	ns contributing to	death but not res	sulting in the unde	erlying cause give	en in Part I	23e. Did	tobacco	use contribute	to the caus	se of death?
Fires t	signe d be o	l by					,		1 🗆			Probably	4 Junknown
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slcla	s cert lirecto	o Be	examiner?  1 Yes 2 No	Hospital:	Inpatient 2	] ER/Outpatient	3 DOA Othe	or'	ath <i>(Check only c</i> Home 5 ☐ Resi				
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tending Phy	r: Aft	ioi l	1 Natural 5 ☐ Pending 2 ☐ Accident investig		onth, Day Year)	Injury		K? Yes 2 □ No					
Atte	ecto ecto by th	ific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Pla	ce of injury - At h	ome, farm, street fy)	, factory, office		28f. Location (	Street a	nd Number or	Rural Rout	e Number,
2 p	s arre	Certification:	4 Internation	Dui	iding, etc. (Speci	'97			City of To	WII, SIAI	e)		
To the Hospital or Attending Physician:	winning the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	g Physician: To t Examiner: On the and ma	he best of my kno basis of examina	owledge, death o ation and/or inves	ccurred at the tin stigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time	cause(s , date an	and manner d place, and d	as stated. ue to the c	ause(s)
To the	To th	Me	29b. Signature and title of certifier				29c. License	e number		29d. Da	ate signed (Mo	nth, Day, Y	/ear)
-			A-L.	Pi			RE	5-000		MA	rch	19	2008
	, I		30. Name and address of person v	vho completed ca	use of death (Iter	n 23a) (Type, Pri	nt)					1	
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			State of Maryland / Departn	nent of Health and Iv Cate of Death		2008	ngini
			1. Decedent's Name (First, Middle, Last)	cate of Death	2. Date of Death	g. No. 🕒 🔾 🔾 🔾	3. Time of Death
- 10	Physici		LONNIE ORIS BELL		Month MARCH	19, 2008	1:05 P M
	/Medio		4a. Facility Name (If not institution, give street and number)  4b.	. City, Town, or Location of Death	11111111111	4c. County of Death	<u> </u>
			302 BISHOP COURT	WESTMINSTER		CARROLL	
	Funeral		1MM 2DE	Under 1 Year   If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		215-80-1434   1XIM 2LIF   46 Yrs.		12/19/1	961 MARY	YLAND
	land ow		10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
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	or 282	Director	10e. Street and Number	Df. Zip Code	10	g. Citizen of What Cou	itry?
	23a ust b	la l	302 BISHOP COURT	21157		USA	
	er deg	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. If Yes 1 □ Yes 2 □ No	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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pug	be fill ntal H od oth even	Be	17. Father's Name (First, Middle, Last)  ROBERT BELL, SR.	18. Mother's Name		aiden Surname) BODKIN	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 Is marked other than "natural"; or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	유		Idress (Street and Number or Rura			Code)
<b>≥</b>	nd 2 s Ilth an 27 Is r r trau			•		ER, MD 21	,
ē,	1 a He He ithe		20a. Method of Disposition 20b. Place of Disposition	<u>.</u>		Oc. Location - City or T	
Ë	Pages nent of h int: If ite		I Younai 2   Cremation 3   Removal from State	CEMETERY 3/22	/2008 F	PATAPSCO,	MD
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licensee 22. Nat	me and Address of Facility FL	ETCHER	FUNERAL H	HOME, P.A.
	9 9 F 6 9		V 1-1	E. MAIN ST,			
2	Physician /Medical Examiner pnual-transit	Examiner	23a. Part1. Enter for disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on exchains.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any season of information cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	UM CA	gn Ce	-	Approximate Interval Between Osset and Death
92	be bur	ā	d				
687	tificate ig phy as the	ledic				1	
P.O. Box	Physician: The law requires that the death certificate this certificate has been signed by the aftending physrat director, page 2 should be detached for use as the	Physician/Medic		opic pregnancy er (specify)		23d. Date of deliv Month	ery Day Year
	uires that the designed by the	by	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tob		he cause of death?
Records,	w requii been s should	Completed			24a. Was an	24h Were auto	opsy findings available
Be	'sician: The law s certificate has b lirector, page 2 sl	dwc			autops) perform	prior to co	impletion of cause of
ta	an: Trifical	BeC	25. Was case referred to medical	26. Place of Deatl	1 Yes 2 h (Check only one		2 □ No
or Vital	nyslel nis ce I direc	To B	examiner? 1   Yes   2   No	☐ DOA Other: 4 ☐ Nursing Ho	me 5 Reside	nce 6 ☐Other (Speci	fy)
0	ing Pl	.uo	27. Manner □eath 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe ho	w injury occurred	
Division	ttendi Jeath. Stor: /	cati	2 ☐ Accident investigation		20f Location /Ctr	eet and Number or Run	al Pouto Number
Di√	affer affer I Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	actory, critice	City or Town,	State)	a rioute iquinoei,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occ and manner stated.  Check only one)	urred at the time, date and place, gation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as sate and place, and due t	itated, to the cause(s)
	To the within To the complex c	Me	29b. Signature and time of certifier	290. Let Berner pumber 03 03	29	od. Date signed (Month, $3/20/03$	Day, Year)
	le		30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	ter Street Live	Stune	er un o	1157
	Sta	ite	31. Date filed (Month, Day, Year)		د ۱-۱۱۰۰۰ مر	TILL SE	
	Registr	ar	MAR 2 1 2008				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month Day **Physician** ermaun /Medical Name (If not institution, give street and number) 4c. County of Death Examiner TOSDIC **Carroll County** Westminster If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs **Funeral** Months 1 X M 2 □ F Director **Poland** 057-32-3230 Jul 9, 1924 Usual Br 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8220 Snowden river Pkwy. Marital Status Amed Forces? 1 Yes 2 No Funeral 21045 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. p A 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) filed within Hygiene. College (1-4or 5+) Broadcaster Radio Pages 1 and 2 should be filed vent of Health and Mental Hygie int; If item 27 Is marked other t 54 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Peter Antonovich Bytchkowsky Anna Troitsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trace 6336 Cedar Lane Apt. 121 Columbia, MD 21044 Ania Bykowsky Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1≥ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount View Cemetery 22. Name and Address of Facility Mar 19, 2008 Marriottsville, Maryland 21. Signature of Funer J S rvice Lice Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the obease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and strans Due to (or as a consequence of): Box 68760. Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed certificate has been rector, page 2 shoul 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUSE 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one 29c. License number 29b. Sign tre and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of pe

31. Date filed (Month, Day, Year)
MAR 2 1 20

2008

rson who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** William vard 04:54PM MARCH 18. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 M 2 □ F 218-26-4613 Director recland, MI Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits A anyward Hygiene.
And Mental Hygiene.
Is marked other than "natural" or items 23a or 28a-f show
warde event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTI MORE Director MD nler 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 11205 by Funeral 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Men Important: If item 27 Is marker any Injury or other traumatic ပ ehman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 ana 110tc  $M_{\perp}$ rouse 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State Air Memorial Gardens 108 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses BACAMORO, MDZ1234. Freneral Chaselal TOLAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYOCARDIAL INFARCTION HOURS /Medical Due to (or as a consequence of) Examiner ACUTE GASTRIC INTESTINAL BLEED DAYS Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transi FAILURE ACUTE RENAL HOURS Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day signed by the a Id be detached fo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 this certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 08 D63974 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMRON SIDDIO Date filed (Month, Day, Year) D 76.011 32. Registrar's Si OSLER DRIVE TOWSON, MARYLAND State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Mary L. Cook March 16 2008 12:17 PM<sup>V</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 214-07-2449 1 □ M 2 1 F 91 Director March 11 1917 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Washington be notified Williamsport Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or items or or other traumatic event, the Medical Examiner must be r 8138 Neck Rd 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lpn Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Loda Lepley Pleasant Rebecca Beall ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Williams Jr. (Son) 8138 Neck Rd, Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. CrestLawn MEM Park 4 □ Donation 5 □ Other (Specify) March19,2008 Marriottsville, MD 22. Name and Address of Facility
Haight Funeral Home & Chapel, PA (PO BOX 195)
Sykesville, MD 21784 21. Signature of Funeral Septice Licenses 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burian-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2

No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 ☐ Pending investigation 1 Tes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title

Registrar
DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#20b, Der DVR., G877, 3/21/08 WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ASING **Physician** MARCH 1042 AM RBANA 16 2008 /Medical 4c. County of Dea 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GLEN BALTIMORE WASHINGTON MEDICAL BURNIE 8. Date of Birth (Month, Day, Year, 05-25-1931 5. Social Security Number Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Vear) Country) Philippines 1 ☐ M 21 K F 586-27-2850 76 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8029 Crainmont Drive 21061 Philippines by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Asian 3₺Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anastacio Abing Mabale Ursula Hacot (unknown) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Mr. Romualdo Mable Casing/son 8029 Crainmont Drive; Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date March 20, 2008 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 3 Stevensville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 1 2nd Ave SW; Glen Burnie, MD 21061 Services 21. Signature of Funeral Service Licensee MO1357 Parense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a convequence of): Examiner Sequentially list conditions, if any had not immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner donsequence of): Physician: The law requires that the death certificate be executed and burial-trar Due to on as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an was ... autopsy performed? Yes 2 No certificate has 21 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl -e examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Anpatient Medical Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of D ath 1 Natural 2 ☐ Accident Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

MD

32. Régistrar's Signatu

08-01916 Sean T. Cope Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Me for State amend #4a&b Per ME Certificate of Beath	ental Hygi	iene Reg. 1	No. 20	08 0910			
Physician/	1.1	alstrar Decedent's Name (First, Middle,Last)	2.	Date of Death	ay Year	3. Time of Death 2250 hrs			
ledical Examiner		Sean T Cope  Facility Name (if not institution, give street and number)  4b. City, Town, or Locati		March 7, 200	4c. County of Death				
	48	423 Burbank Street 1110 Fidler Lane Washington S	Silver S		Montgomery				
Funeral Director		Social Security Number 6. Sex	Under 24Hrs. 8 Hours Min.	3. Date of Birth(N	MM/DD/YYYY) 9. Bir 1/989 Foreig Co	thplace (State or gn buntry) Wash., DC			
2	Us	sual Residence of Decedent				10d. Inside City Limits			
iow any		DC 10b. County 10c. City, Town of Education 10c. City, Town of Education 10c. City, Town of Education				1 Yes 2 No			
the Maryland to 28a-f show	10	De Street and Number 10f. Zip Code			Citizen of What Cou				
the Man or 2 stiffed		423 Burbank St SE 20019	0.1-1-0.7.8222	_	nited Sta	rican Indian, Black,			
tems 23	11	1. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 No  13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	xican, Puerto Ri	can, etc.)	White, etc.	ack			
fter death ", or ite ter must y Fun		B Widowed 4 Divorced If Yes, Give Year 1 Yes 2 1 No spe			Specify:				
hours afte natural"  Examine ed by		15. Decedent's Education (Specify only highest grade completed)  Flementary/Secondary (0:12)  College (1-4 or 5+)  College (1-4 or 5+)	Give kind of wor NOT use retired		6b. Kind of Business				
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar Completed		12th Student			NA				
1215-0036 Idee filed within 72 hours after death with the Maryland fental Hygiene.  Narked other than "natural", or items 23a or 28a-f sho event, the Medic I Examiner must be notified at once.  Dee Completed by Funeral Director		7. Father's Name (First, Middle, Last)	Nother's Name (F		iden Surname)				
		19h Mailing Address (Street and	d Number or Ru	ral Route Numb	Number, City or Town, State, Zip Code)				
tore, MD 2 gges 1 and 2 shou at of Health and N it If item 27 is an other traumatic	1	Marilyn Egerton Foster mother 2005 Jackson	13t N	E Wask	nington, Do	C 20010			
ore, it ite		Oa. Method of Disposition  Burial 2 Cremation 3 Removal from State  Donation 5 Other Specify:  20b. Place of Disposition (Name of cemeter crematory or other place)  CIENWOOD (EMETER)	11 12/2 12/2	00/2008	washing	ton, DC			
는 K 및 필드님		4 Donation 5 Other Specify: CFU COCC (EMBT)  1. Signature of Funeral Cryin, Licensee 22. Name and Address of F	Facility	xc pocco	J	20 00011			
Balti permit. Departor Imports	1	Branchi 814	t upshi	ir 3t N	iw wash	Approximate Interval			
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aminer		mmediate Cause (Final disease or condition resulting in death)  a. Sharp Force Injuries  Due to (or as a consequence of):				- 3			
, =		Sequentially list conditions, b							
nsit Agentic	i lue	Leading to immediate Due to (or as a consequence of):  Enter Underlying Cause ase or injury that initiated							
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Box 68760  e death certificate the attending physical for use as the burden for the attending physical for use as the burden for use	<u>e</u>	past 12 months?  4 Pregnant at time of death 5 Other (Specify)							
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ords, v requires been should	Completed			24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?					
Recontraction The lay page 2	E		(D - 4) (Ob - 4)	1 Yes 2 No 1 Yes 2 No					
ician:	<u>ا ھ</u>	examiner? Hospital:   Inpatient 2   ER/Outpatient 3   DOA   Oth	f Death (Check of ther: Nursin		Residence 6 🗸 O	ther: Scene			
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the ray after death.  The rector After this certificate has been signed by led in by the funeral director, page 2 should be detact.	읽	1 ✓ Yes 2 No 28b. Time of Injury 28c. Injury a		28d. Describe h Subject ass	now injury occurred				
ion tendin eath. for: A the fur	譩	Penalty	s 2 V No	-		r Rural Route Number, City			
Divis spital or At hours after d meral Direc y filled in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office built	laing, etc.	or Town, S 1110 Fidler La	State) ane, Silver Spring,	MD			
bound of the post		4 V Homicide	and place, and	due to the caus	e(s) and manner as	stated.			
To the within 2	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, or and manner stated.		at the time, date	29d. Date signed				
	Σ	29b. Signature and title of certifier  O.C.M.			March 8, 200				
2	}	30. Name and address of person who completed cause of death (Item 23a)							
2		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimon	re, MD 2120	)1 					
Sta	ate	31. Date filed (Month, Day, Year)  MAD 2. 1 2008  Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24a, 25, 26, 27, 30 Department of Health and Mental Hygiene per dr. 987, 03/21/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:35 PM<sup>™</sup> William Coles March 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**∑**M 2□F Director 19, 74 1933 Apr Usual Residence of Decedent 10a. State unk 10c. City, Town or Location 10d. Inside City Limits show unk r 28a-f shov notified at unk unk¹□Yes 2□No Director 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 □ No If Yes, Give unk 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by Specify: black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be unk of Health and Menta ဥ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Sign rure of tun ral Se Licensee Walde State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Kavasular coagulation burial-transit be executed Due to (or as a consequence of) Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Yea 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopo performea: No this certificate 1∐ Yes 2 No or Vital Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 an

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's MAR 2 1 2008

Van V. Mai, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Carroll Ave.,

Takoma Park, MD 20912

State of Maryland / Department of Health and Mental Hygiene For

		1 - State Registrar		Ce	rtificat	e of i	Death		Reg.	No. 4 U	UÖ	03100
V I 5	- 1	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day								3. Time of Death		
Physician /Medical		Arthur John Carmichael								Day Yea 18, 2008		4:40PM M
Examin		4a. Facility Name (If not institution, giv	re street and number)		4b. City,	Town, or	r Location of De			4c. County of		14.40FM
	•	Map1e	wood Park P	1200		1	Bethesda	9		M	onto	omery
Funeral		5. Social Security Number 6. S		n yrs. last birthday,		1 Year	If Under 24 H	rs. 8. Date	of Birth			place (State or Foreign htry)
Director		577-90-3202	IXM 2□F   91	Yrs.	Months	Days	Hours Mi	n. Octobe	h, Day, Ye $r 25.$	1916		otland
pr ,		Usual Residence of Decedent	146	- 01 T								
arylar show	_	10a. State 10b. County	10	c. City, Town or L	ocation						1	10d. Inside City Limits
e Ma	Director	Maryland Montg	omery			]	Bethesda	a .				1 ☐ Yes 2 X No
or 28a-f show	Ë	10e. Street and Number			10f. Zip	Code			10g.	Citizen of W	hat Coul	ntry?
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or it		1 ☐ Never Married 2X Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes		Specify:	,	,	Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			24						White
72 t	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	edent's Usua e kind of wo	al Occup <i>rk done d</i>	ation during most of w d)	orking	16t	o. Kind of Bus	iness/In	dustry
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lled v dygie her t	රි	17 Fathara Nama (First Middle Leaf	4		C1V	11 1	Ingineer		:441 4 44-1			Bank
be fi	Be	17. Father's Name (First, Middle, Last					18. Mother's N	ame ( <i>rirst, M</i>	idale, Mai	aen Surname	?)	
i Mei i Mei narke	2		John Carmic							n Reid		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified once.		19a. Informant's Name/Relationship (		19b. Maili	ing Address	970	and Number or 1 17 01d G hesda,	Hural Route N eorget	own_[	Road #	State, Zip L 15	Code)
t and lealt lm 2		Sarah Carmicha 20a. Method of Disposition		20b. Place of Disp	osition /Mar	Bet	hesda,	Marÿla Date				
ges If of h		1 ☐ Burial 2 🕅 Cremation 3 ☐		cemetery, cre Montgom	ematory or o	ther plac	ce)   N	larch	200	c. Location - C	ity or 10	own, State
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permit Depar Impor any In		21. Signature of Funeral Service Lice	nsee	Be	2. Name an	id Addres Ia−Ch	ss of Facility KC	bert A	Pui	mphrey 557 พี่เ	Fun scon	eral Home/ sin Avenue
20 = 60		Jen 1	t MO	00335 Be	thesd	la,Ma	nevy Ćha aryland	20814-	3501		30011	SIN AVERGE
		23a. Part1. Enter the lisease, or on shock, or heart failure.	ications that caused the one cause on each line.	death. Do not en	ter the mod	le of dyin	ig, such as card	iac or respirat	ory arrest,			Approximate Interval Between
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Examiner		Sequentially list conditions.	b									
D √ 1 #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated overter	Due to (or as a co	onsequence of):								
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certificate be executed ding physician and se as the burial-transit	/Medical	IF FEMALE:								T		
	by Physician/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐		□Ectopic pr	egnancy	,			23d. Date Mon		
e deg		1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown						IVIOIT	ui	Day Year		
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law las be	Completed							24a.	Was an autopsy	24b. W	ere auto	ppsy findings available
The ate h	등							10 \	performec	1? de	eath?	mpletion of cause of
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hysic nis ce I dire	ပို	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DC	Othe	er: 4K Nursing	Home 5	Residence	e 6 □Othe	(Specit	y)
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er de recto	<b>≝</b>	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)  5 ☐ City or Town, State)							r or Rura	al Route Number,		
talo s aft al Di	Certification:								iaro			
hour hour uner		29a. Certifier  (Check only  2 Medical Example 1	nysician: To the best of miner: On the basis of ex	y knowledge, deal	th occurred	at the tin	ne, date and pla	ice, and due to	the caus	e(s) and man	ner as s	tated.
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	one)	and manner stated		rveouyatiOff	, iii iiiy O	pilion, death of		ume, date	and place, a	na aue t	o trie cause(s)
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1			elf)	10			D26259			Marci	19	, 2008
15	t	30. Name and address of person who	completed cause of death	ı (Item 23a) (Type,	Print)					.141 (1	<u> </u>	, 2000

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

MAR 2 1 2008

Ava A. Kauffman, M.D. 8218 Wisconsin Avenue #103, Bethesda, Maryland 20814

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State Registrar	epartiment of Mea		ntal Hygie Reg.	0000	00100
8.	Physici		1. Decedent's Name (First, Middle, Last) HENRY	600	2.	Date of Death Month	Day Year 9 2008	3. Time of Death 06 47 M
-	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  THE JOHNS HOPKINS HOSPITAL  5. Social Security Number  6. Sex  7. Age (In yrs. last birt)  217-90-5008  1 Am 2 F  45	hday) If Under 1 Year If	ocation of Death	1717	4c. County of Death  N/A	place (State or Foreign
	P	ŗ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town		112	<i>ar on 191</i>		0d. Inside City Limits
	with the M 3a or 28a-f st be notifie	Il Director	Maryland Baltimore Balti  10e. Street and Number  7395 Edsworth Road	10f. Zip Code 21222			1 $\square$ Yes $2 \square$ No . Citizen of What Country? $U.S.A.$	
036	be filed within 72 hours after death with the Maryland that Hyglene.  do offier than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☐ No  If Yes, Give Λ  Year or Dates:	13. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Specif Mexican, Puerto Ric Specify:		14. Race - Americ Black, White, Specify:	etc.
Maryland 21215-0036	within 72 ho lene. r than "natur the Medical 8	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12.	Decedent's Usual Occupatio (Give kind of work done duri life. DO NOT use retired) Dependent	on ing most of working	1	Whi: Kind of Business/Ind	dustry
yland 2	ed ala	To Be C	17. Father's Name (First, Middle, Last)  Henry A. Cook		3. Mother's Name (F	irst, Middle, Maid	den Surname)	<u> </u>
	1 and 2 s Health ar em 27 ls ther trau		Mrs. Frances Bowman/Sister 78  20a. Method of Disposition 20b. Place of	Mailing Address (Street and 03 Jamesford Disposition (Name of Archardry) or other place)		dalk, Ma		222
Baltimore,	permit. Pages Department of I Important: If It any injury or o		TELEBOTIAL 2 LICIETTATION 3 LINETHOVALITOTI State	ridge Mem. Po 22. Name and Address of 7922 Wise At	ark 3/15, of Facility Duda	/08 Ba -Ruck F.	Altimore, M	Maryland dalk,Inc.
8/60,	cate be executed hysician and hysician and Examiner the butal-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause of the cause) Due to (or as a consequence of the cause) Due to (or as a co	ot enter the mode of dying, s HOCK the sistant Staph the sistant Staph	such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death 3 HOURS
O. Box 6	ath certifi attending   for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive	ery Day Year
ords, P	w requires that the de been signed by the should be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in	n Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
Vital Records	The la ate has page 2	Completed	OF Was associated and the state of the state			24a. Was an autopsy performed Yes 2 □	?   death?	psy findings available inpletion of cause of
10 U	ng Phys fter this ineral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No	oatient 3 DOA Other: me of ury 28c. Injury at Work?			6 □Other (Specifi	(Y)
DIVISION	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral Director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)			City or Town, St		
	the Hosp hin 24 hou the Fune apletely fi	Medical	29a. Certifier  (Check only one)  1 ★Certifying Physician: To the best of my knowledge, 2 ★ Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opini	ion, death occurred	at the time, date	and place, and due to	the cause(s)
	or Neith		29b. Signature and title of certifier  Rebecce alslahsen MD	RES-0			RCH 9 2	_
	0		30. Name and address of person who completed cause of death (Item 23a) (TREBECCA ASLAKS ON THE JOHNS HOPKINS	YPE, Print) HOSPITAL GOOM	V. WOLFES	T. BALT.	IMORE HD	21287
	Sta Registra	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature	100				

ORIGINAL

08-02132 Clifton Sylv	ester			<b>pe or Print in Bl</b> tate of Maryland	/ Depart		alth and Ment		ene		2008	3 0911
Phy Medical Ex	ysicia xamir	n/ ner	egistrar I. Decedent's Name (First, Middl Clifton	Sylvester	Cl	nilds	ty, Town, or Location of	M	ate of Death	Day 2008		Time of Death 1056 hrs
Fun	neral		4a. Facility Name (if not institution 568 Wilson Bridge Dr. 5. Social Security Number	rive Apt. A-1	je (In yrs. las	O)	on Hill	er 24Hrs. 8.	Date of Birth	Prince	e George's	place (State or Wash DC
Dire	ctor		231-88-4977  Usual Residence of Decedent	1 <sup>X</sup> M 2 F	46	Yrs.	onths Days Hours	Min.	7-08-	1961	Cour	
yland	-f show any once.		10a. State 10b. County MD 10e. Street and Number	PG	10c. City, T		n Hill		1 10	a. Citizen o		1 X Yes 2 No
vith the Mar	s 23a or 28a notified at	Dire	568 Wilson D	Or. #A1	t Ever in U.S		20745	gin? ( Specify		U 14. F	SA Race - America	an Indian, Black,
after death w	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	1 Never Married 2 No 3 Widowed 4 Div	Arried Armed Forces  1 Yes 2  vorced If Yes, Give Year or Dates:	? X No	If Yes, s	2 X No specify:	, Puerto Rica	an, etc.)	Spec	White, etc.	
36 thin 72 hours te.	than "natur edical Exam	npleted I	15. Decedent's Education (Spe Elementary/Secondary (0-12)		7	during most o	sual Occupation (Give f working life. DO NOT chanic		done		ivate	dusti y
MD 21215-0036 td 2 should be filed within 7 ttth and Mental Hygiene.	arked other vent, the M	Be	17. Father's Name (First, Middle Hampton	Childs			18.Mother Sall			Wils	on	Zin Code)
MD 2' 12 should th and M	127 is ma umatic e		19a. Informant's Name/Relation: Tasha Childs			1535 F	t. Davis	St.	SE Wa	sh.		020
Baltimore, permit. Pages 1 and Department of Heal	ant: If iten or other tra		20a. Method of Disposition  1 Burial 2 Crematio  4 Donation 5 Other S	Specify:	cr	ematory or other p shingto	n Nat'l	03/29	ete 9/08	Suit	land,	MD
Balti permit.	Importi injury o		21 Signature of Funeral Service	Rabu		108	and Address of Facilit	Ave.	Balt	imor	e, MD	
Physi /Med Txam	dical		23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line.	oxicati	on	ode or dyllig, such as t	cardiac of res	spiratory arre	31, 311000,	n ricuit	Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								*1
executed	ın and ıl - transit	<u>a</u>	X UNPENDED	d	27. 28a	-f per ME	g877 3/27/08					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex-	the attending physician led for use as the burial		IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome the 1 Live birth 4 Pregnant a		ancy 2 Fetal d		ic pregnancy	,	23d. Da Mor	ate of delivery nth D	lay Year
P.O. Bosthat the dea	has been signed by the att 2 should be detached for	by Phy	Part II. Other significant cond	9 Onkilowii	ath but not re	sulting in the unde	rlying cause given in F	Part I.	i			the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the soften death	cate has been s page 2 should I	Completed							24a. Was autop perfo 1 Yes	rmed?		topsy findings available completion of cause of s 2 No
<b>ital F</b>	certifi ector,	Be	25. Was case referred to medic examiner?	Hespital:	ient 2	ER/Outpatient 3	26.Place of Death	Nursing H		Residence	6 V Other	: Scene
of V ling Phy	After t funeral	on: To	1 Yes 2 No  27. Manner of Death  Natural 5 Per	28a. Date of In (Month, Day		28b. Time of Injur	1 Van 2 V	7 No.	d. Describe	how injury o	occurred	
Division	neral Director: filled in by the	Certification:	2 Accident Inv	reduing vestigation ould not be termined Found 3/ 28e. Place of (Specify)Found 5/	Injury - At ho		actory, office building,	UI	or Town, S	Street and I State) 568	Number or Ru Wilson	ral Route Number, City Bridge Dr.
D To the Hospital	within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of ex	amination ar	ge, death occurred nd/or investigation,	at the time, date and p in my opinion, death o	place, and du occurred at th	e to the caus ne time, date	se(s) and m and place,	anner as state and due to th	ed. e cause(s)
OL OF	To COT	Mec	29b. Signature and title of certification in the control of the certification in the certific	A	12		O.C.M.E.	r			e signed <i>(Mol</i>	nth, Day,Year)
	Ø		30. Name and address of person Donna M. Vincenti, N	MD Assistant Med	lical Exam	niner 111 P	enn Street, Baltin	nore, MD	21201			
F	Si Regis	tate trar	31. Date filed (Month Day, Year WAR 2	0 2008 32 egist	rar's Signatu	re Land						
DHMH 17	Rev 1/2	001				ORIGINAL						

State Registra

MEDICAL DOCTOR

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

LES -000

MARCH

GOU NORTH WOLFE STREET BALTINORE, MARYLAND 21287

19,2008

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: 24

ro the Funeral

1 **Extifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. \$ignatur 29d. Date signed (Month, Day, Year) 00060560 30. Name and address of person who d cause of death (Item 23a) (Type, Print) BACK RIVERNEUR RD # 109, BALTIMBE, MD 2. Registrar's Signature 31. Date filed (Menth, Day, Year) State Registrar 2008 **ORIGINAL** 

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2008 0638AM Herman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Baltimor N If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/22/1949 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months 58 Hours 219-52-8091 1 X M 2 □ F MARYLAND Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits show must be notified at MD N/A Director BALTIMORE CITY 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3631 LIBERTY HEIGHTS AVENUE 21215 or items 23a USA death 1 by Funeral 12. Was Decedent Ever in U.S Armed Forces? US 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No MARTNE
If Yes, Give
Year or Dates: CORPS filed within 72 hours after Hygiene. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: BLACK 3 Widowed 4 Divorced "natural", Completed is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11TH COOK CULINARY ARTS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other trailmests. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM H. FINNEY, SR. FANNIE BRITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL FINNEY-FOSSETT / SISTER 234 KATHY DRIVE, MULLUSK, VA 22517 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State METRO CREMATORY 3/19/08 CATONSVILLE, MD 4 Donation 5 Dother (Specify) 21. Signature of Superal Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD her the deease, or complications that caused the death fo not enter the mode of dying, such as cardiac or respiratory arrest, 23a. F Approximate Interval Between Onset and Death iat Cause (Final Depsis **Physician** r condition /Medical Due to ( as a consequence of): Fram regative rod bacterenia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and A certificate be executed the burial-transit Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 I Inknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ pe Hepathti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No page 2 certificate or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**1** No ို 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division the Hospital or Attending 5 ☐ Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

State

Registrar MAR 2 0 2008

6 reene St. Baltimore, MO M.D10 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

March 18, 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 1:15pm Raymond B. Fitzpatrick March 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 615 New Jersey Ave. Essex Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 21, 1950 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** M☐M 2☐F Months 217-58-8233 57 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at Director MD Baltimore Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medic | Examiner must be r 615 New Jersey Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes ŽŽNo Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 721 (Give kind of work done during most of working life. DO NOT use retired) I Administrator Earl Beck Corp. Elementary/Secondary (0-12) College (1-4or 5+) 12th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental Finand Mental Finand Mental Finand Mental Finand Fina Be Raymond A. Firzpatrick Barbara M. MArtin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any Injury or other trau Doris A. Fitzpatrick 615 New Jersey Avenue Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery 3/25/2008 Baltimore MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Connelly FuneralHomeofEssex 300 Mace Avenue Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) the 9 I Inknown 9 ☐ Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes ♀□√No 24a. Was an has page 2 autopsy performed? certificate Yes 2\Q\No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one 2 NO Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Maryland 21215-0036

Baltimore,

State Registrar

Medical

30. Name and address of pe 31. Date filed (Month, Day, Year)

address of person who

V) "

29b. Signature and title of certifier

FOR

and manner stated.



completed/cause of death (Item 23a) (Type, Print)

29c. License number

0001666

29d. Date signed (Month, Day, Year)

FAILS Rd. Lutherville, Md. 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 17, 2008 **Physician** 9:15 Ap\_M Grazia Fornaro /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Rockville Nursing Home 8. Date of Birth (Month, Day, ) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) . Year) 1903 **Funeral** Months Days Hours Min. 1 ☐ M 2 🕅 F Oct. Italy 104 064-10-2242 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 TX No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 7009 Rainswood Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify Specify: White \$ Year or Dates: 3 X Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than Garment Industry ortant: If item 27 is marked other tha Injury or other traumatic event, the I Dressmaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Cutrone Antonio Bellezza 2 and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7009 Rainswood Court, Bethesda, Maryland 20817 Health em 27 i Cosmo Fornaro / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any Injury or March 31, 2008 Robbinsville, New Jersey Princeton Memorial Park 4 □ Donation 5 🛛 Other (Specify) Entombment 21. Signature of Funeral Service Licens Robert A. Pumphrey runeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 23a. Part1. Enter he dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause disease or condition resulting in death) Congestive Heart Failure Physician /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner A pue law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 1 Unknown Chronic Kidney Disease Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No Physician; The 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M within 24 hours after death. To the Funeral Director: 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide Hospital 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier Much 18th, 2008 MD D0064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandeep Sharma, M.D., P.O. Box 83038, Gaithersburg, Maryland 20883

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 2 1 2008

TENE

32. Registrar's Signature

08-02158 Martha Gelin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 0911 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Month Mr-"cal Examiner 1050 hrs Martha March 17, 2008 Gelin 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4 Monroe Street # 404 Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours 216.72.1025 M Country) 41 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. MD Montgomery 1 Yes 2 No Rockville jes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Monroe Street 20850 U.A.A Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Specify: White 3 Widowed Divorced If Yes, Give Year Yes 2 No specify: other than "natural" à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Dept. of Home Land Security 12 Clerk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked Be <u>Jacques Bresler Gelin</u> Margaret I.ittwitz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jacques Gelin/Father VanBuren St. <u>Rockville</u> MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State ltimore. Pages 1 Burial 2 Cremation 3 Removal from State crematory or other place) Chesapeake Crem. 03.21.08 Beltsville, MD Donation 5 Other Specify: 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21/ Signature of Funeral Service Licensee P.A. 8717 Green Pastures Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** failure. List only one cause on each line Between Onset and 'Medical Death a.Cardiac arrhythmia Immediate Cause (Final disease \_xaminer or condition resulting in death) Due to (or as a consequence of): bMitral valve rola se Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68/bu, : The law requires that the death certificate be executed Physician/Medical AMENDED 23a, b, Pt. II, 27 per ME g878 4/9/08 amh the attending physician ed for use as the burial -X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Status post colectomy for ulcerative colitis 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✔ Yes 2 No certificate 1 🗸 Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 this DOA Nursing Home 5 Residence 6 V Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1\_\_\_ Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Suicide Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 18, 2008 my lineal INID 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimpre, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0 Grant Ollvia

**Physician** /Medical **Examiner Funeral** Director

4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltonia rankuille (Yarkwa 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2-5-1920 Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours Min. 1 □ M 2 🔽 F 214-22-3470 Yrs N.C. 88 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show dival Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3201 Avon Avenue 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 赵 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Black Baltimore, Maryland 21215-0036 Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Private Homes 6th grade

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h Grant Gray Hattie Lawrence 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau Allen Wheeler - Son 3201 Avon Avenue Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3-22-08 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East MD 21202 1101 E. north Avenue Balto, indiae 2 tadol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years **Physician** Al3chemers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usesase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown as been signed by 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Acute + Chronic Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dm autopsy has 2 PINO certificate 1⊟ Yes 25. Was case referred to medical examiner? or Attending Physician: 26. Place of Death (Check only one) Other: 4 Avursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide filled in by 4 ☐ Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Wind Kleby 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles 5+ Suna 2120 Whol KISESZ 4202

State

Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Anged Forces? 1 AYes 2 □ No If Yes, Give Year or Dates:	1	Nas Decedent of Hispanic C f Yes, specify Cuban, Mexic I Yes 2 X No Specify		ofy Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify: W	e, etc.
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ı Records,	The lar	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
or vital	hysicien: this certific al director,	To Be	1 Tes 25 No	Hospital: 1 Inpatient 2		3 DOA Other: 4 N	lursing Hom	Check only one) e 5 Residence	e 6 □Other (Spe	city)
DIVISION	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	27. Many r of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be  4 Homicide determined		28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2	□No	3d. Describe how 3f. Location (Stree City or Town, S	at and Number or Ri	ural Route Number,
ב	Hospital o	Medical Cer	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsicien: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death	occurred at the time, date a estigation, in my opinion, de	and place, areath occurred	ad due to the caus	se(s) and manner as	s stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier  Aushin Offe			29c. License number			Date signed (Mont	
	6		30. Name and address of person who o			Print) MOSPITAL	OF	BALTI	MORE	
	Sta Registra		31. Date filed (Month, Day, Year)  MAR 2 1 200	32 Registrar's Sign		li				

DHMH 17 Rev 1/2001

State Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State of M	larylan	•	rtment of <i>tificate o</i>	Health and f Death	Mental Hy	giene Reg. No	ΠΩ	00122
			1. Decedent's Name (First, Middle, La	ist)					2. Date of De	ath		3. Time of Death
	Physiciar '/Medica	_	Betty Rae Mi	les Hill					Month March	17 20	Year 08	7:15a
Painte	Examine		4a Facility Name (If not institution, gir						Location of Deat			
			Montgomery Coun				WHI I WAY	01ney		Montg		
ı	Funeral Director			4 🗆 14 . a 🖂 . E	ge (In yrs. '7	last birthday) Yrs.	If Under 1 Yes Months Day				9. Birthpla Countr	ce (State or Foreign y)
	Du ¥	- 1	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	ration	<u> </u>			10	d. Inside City Limits
	sho		MD Howard			ton	Action					1 □ Yes 2√√ No
	28a-1	5	10e. Street and Number				10f. Zip Code	)		10g. Citizen of V	/hat Countr	
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "hatral", or items 23a or 28a-f show important: if item 27 is marked other traumatic event, the Madical Examiner must be rottled at once.		4581 Ten Oaks Roa	ad			21036			USA		
	ems	E	11. Marital Status	12. Was Decedent		,S. 13. V	Vas Decedent o	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Raci Blac	e - America k, White, et	
20	s afte	yo.	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:			□Yes 2117 N				white	e
8	turai sturai	8	15. Decedent's E			16a. Deced	ent's Usual Occ	cupation		16b. Kind of Bu		
215	hin 7%		(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or	5+)			ne during most of wi ired)	orking	coriou1	+xo	
21	ygiene. ygiene. rer than "nature it, the Maureal	5	12		,	offic	e manag	1		agricul		
Maryland 21215-0020	be file d oth		17. Father's Name <i>(First, Middle, Lasi</i> Harry Clayton Mi	•					ame (First, Middle Sealing	, Maiden Sumam	e)	
Z S	d Menid Insulta	2	19a. Informant's Name/Relationship			10h Mailin	a Address (Stre	eet and Number or F		ner City or Town	State 7in (	Code)
Ma	d 2 sl th an 7 is r traur	Ì	Janice Hill (daug					108, Cla				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ē,	s 1 end 2 F Health tem 27 is		20a. Method of Disposition	10		Place of Dispos	sition (Name of		Date	20c. Location -		n, State
altimore,	Page: ent o nt: if i		1 Donation 5 Other (Speci		Lir	iden Li	nthicum	olace) Cemetery	3-20-08	Clarksv	ille,	MD
alti	permit. Pages 1 Depertment of H Important: if ite any injury or ot once.		21. Signature of Funeral Service Lice	nsee		22	Name and Add	dress of Facility $_{ m Ha}$	aight Fu	neral Ho	ne & (	Chape1
m	88 5 28		Daugh Hought	Henkers	+	Р.	O. Box	195 Sykes	sville, l	ID 21784		
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause one cause on each	ed the deatl line.	h. Do not ente	er the mode of o	lying, such as cardi	ac or respiratory	rrest,		Approximate nterval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final			,					-	4.
	Examiner		disease or condition resulting in death)	a		MIMITER		cow c	min			1 4 FM
		<u> </u>			Due to (o	or as a conseq	uence or):				1	
	ficate be executed by physician end as the burial-transit		Sequentially list conditions,	b	Due to (o	n as a conseq	uence of).					
90,	oe execian e	E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C								*
68760,	physics the b	2	that initiated events resulting in death) Last		Due to (or	r as a consequ	uence of):					
Box (			· ·	d								
	death e atten	2	Part II. Other significant conditions	contributing to death	but not resi	ulting in the ur	derlying cause	given in Part I.	23b. Did	tobacco use cor	ntribute to	the cause of death?
P.0	The law requires that the death certivate has been signed by the attending page 2 should be deteched for use a page 4. The physician March and the physician March and the physician March and the physician March and M		•	•			, 0		1	Yes 2 No	3 ☐ Probe	ably 4 Unknown
	se gg a	5							-		0.45 14/	o autonou findingo
of Vital Records,	The law require sate has been si pege 2 should I								24a. Was	s an autopsy ormed?	avai	e autopsy findings lable prior to spletion of cause
360	has b											eath?
a		3	OF \\\	T				00 Di (D		Yes 2 No	1	Yes 2□ No
₹	Physician: rthis certifica ral director, p		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆	ER/Outpatien	3□ DOA	Whor:	eath (Check only	one) idence 6 □Oth	er (Snecify	)
0	Phy erthis eral c		27. Manner of Death	28a. Date of Inj	ury	28b. Time of Injury	28c. In		7	how injury occur		
jo	ath. or: Aft he fur		1 Natural 5 Pending 2 Accident investigation	n	.,,	,,		☐Yes 2☐No				
Division	lal or Attending P is after death. al Director: After tied in by the funera		3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Place of it	ijury - At ho tc. <i>(Sp</i> ec <i>if</i> )	ome, farm, stre y)	et, factory, office	Ce Ce		(Street and Numb wn, State)	er or Rural	Route Number,
	Hospital of 24 hours a Funeral D stely filled in the call Call Call Call		29a, Certifier 127 Certifying Pl	nysiclan: To the best	of my kno	wledge death	occurred at the	time date and place	ce and due to the	cause(s) and ma	nner as sta	ited.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	200	(Check only one)	miner: On the basis of and manner s	of examinat	tion and/or inv	estigation, in m	y opinion, death occ	curred at the time	date and place,	and due to	the cause(s)
	within 2 To the comple	E	29b. Signature and title of certifier	4 /			29c. Lice	ense number		29d. Date signe	d (Month, D	Pay, Year)
			210	111			10	725947		mmax	17,	1008
	10		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type, I	Print)					nay, Year)  2008  W\$3L
	1,		The start of the	you mon	341	6 OLD	muron	y wount	SUME	100 10	LMZy	mp
	State		31. Date filed (Month Day, Year)	008 34 Hegist	iars signa	190						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 11, 3:10 A M RIDDICK HINES JR 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges 2116 Trafalgar Drive Fort Washington If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ★M 2 □ F Yrs. 238-46-9224 8-17-1932 N. Ca. 75 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 🛣 No Director Md. Fort Washington Prince Georges 10g. Citizen of What Country? 10e. Street and Number 20744 USA 2116 Trafalgar Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married res ∠⊔No If Yes, Give Year or Dates: **KOREAN** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dept. Of Corrections permit. Pages 1 end 2 should be filed v
Depertment of Heelih and Mental Hyge.
Important: it Item 27 is marked other tt
any injury or other traumatic avent, IIIs
ance. 12th Correctional Officer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lucy Ann Epps Riddick Hines, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2116 Trafalgar Drive Fort Washington Jimmie Lee Hines Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) ty⊒Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 3-20-2008 Prince Georges, Md. Veterans 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stitaues Schimunek Funeral 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC SQUAMOUS CELL CARCINOMA OF LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inifiated events resulting in death) Last Due to (or as a consequence of): Examine sicion and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ine in attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ete hes been signed by the page 2 should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 No 2 X No 1 Yes After this certification, funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation efter death. I Diractor: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide filled in To the Hospital within 24 hours of To the Funeral D La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier right MD MD# 13140 MARCH 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA ANN WRIGHT, M.D., VAMC WASHINGTON, DC 20422/688 50 IRVING STREET NW 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** Dorothy R. Hallett /Medical March 20 2008 7:50 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Baltimore Gilchrist Hospice Center Towson If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 195.38.3772 Yrs. 90 Director 06.03.1917 MA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits a or 28a-f show t be notified at show Director 1 TYes 2T LNo MD Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a cliner must be 1055 N. Joppa Rd. U.S.A. 21204 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married ò Baltimore, Maryland 21215-0036 1□Yes 2☑No Specify.White 3. Divorced 4 □ Divorced Than 2 Should be filed within 12 inc...
Health and Mental Hyglene.
Hem 27 is marked other than "natural"
went, the Medical Ex 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othel any Injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Eldridge Rogers Helen Stevens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5 Levett Island La., Harpswell, ME 04079</u> <u>Bob Hallett/Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 03.21.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast mcc 42N3 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl on Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

e Funeral Director: After this Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred I or Attending I after death. 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58301 march 20 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QV. 6701 N. Cerarles ST TONSON 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible lak Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 0119 Phillip 2008 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Helfconcenter 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 03 21 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□M 2□F Months Days Hours Min 218-44-8419 46 MD Director 61 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1**∑**]Yes 2□No Director NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21206 5511 Bowleys Lane apt 1-C Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏖 No Specify: þ Specify: 3 ☐ Widowed 4 K Divorced Nlack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) ementary/Secondary (0-12) 12th grade na Artist Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy Alston Mary Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 5511 Bowleys Lane Apt l=C, Baltimore, Chywon Hill-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Cremaotry Inc 3/20/08 Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimaore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shows, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 24hours Renal FAILURE /Medical Due to (or as a consequence of): Examiner 2 hours Hyperkalemin Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of Examine attending physician and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1□ Yes I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P Impatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/14/2008 RES - 000

Registrar

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MAR 2 0 2008

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Eastern Avenue BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year /Medical Cecil Hamblin 18 2008 March 10:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium <u>Stella Maris Hospice</u> Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 17 M 2 F Hours Min. Director 403-26-6772 Usual Residence of Decedent 08-03-1923 Tennessee filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 10d. Inside Cify Limits Director Harford MD Edgewood 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United <u> 1223 Chipper Drive</u> 21040 States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Y Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No ģ Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ HamblinMartha Huddleston Wren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health and Pages 1 and 2 Dolly Hamblin (Wife) 1223 Chipper Drive Edgewood MD 21040 20b. Place of Disposition (Name of cometery, crematory or other place)

Crest Lawn Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or or 14D Buriai 2 □ Cremation 3 □ Removal from State 03-22-2008 4 ☐ Donation 5 ☐ Other (Specify) Marriotsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Avenue Dundalk MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □Yes 2**X** No 2 □No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 X No After this P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: the 1 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide hours after filled 29a. Certifier ca (Check only one) within 24 and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9108

Registrar

State

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) MAR 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



TIMONIUM, MD 21093

10:05

18, 2008

MARCH

CECIL HAMBLIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genera olumbia If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What ö Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23. 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 NeverMarried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be Henderson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Surial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Jurieral Service Lie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ocarbial INFARCITON Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minisolate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attending Physlclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Ho Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Vitin 24 hours after deam,
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS3987 March, ? 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 Alm Of Y PL, Suite 36 BAC 31. Date filed (Month, Day, Year) State MAR 2 1 2008 Registrar

08-02056 Jar

amend items 28a,f per me g879 5-6-08 vt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 09128

es L. Jarvis		For State Control of Postation	Reg. No.
Physicia		. Decedent's Name (First, Middle,Last)	Oate of Death  Onth 13 COOP  3. Time of Death 1345 hrs
<sup>⊸t</sup> Examir		James Lewis Jarvis  a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	March 13, 2008 1345 ftrs 4c. County of Death
	4	Washington Adventist Hospital Takoma Park	. Montgomery
Funeral		i. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8.	. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	1		03.25.1981 Country) FL
any		July	10d. Inside City Limits
<u> </u>	١	MD Montgomery Tacoma Park	1 Yes 2 No
larylar 28a-f s at on	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
i with the Maryland ms 23a or 28a-f show be notified at once.		704 Chaney Drive Apt. 5  112. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci	USA  fy Yes or No. 14. Race - American Indian, Black,
th with	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.) White, etc.
ter dea		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: White
hours afte 'natural'', Examiner	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of word during most of working life. DO NOT use retired	k done 16b. Kind of Business/Industry
136 hin 72 ho e. than "no edical Es	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	unk
5-0036 iled within 72 Hygiene. I other than '	Completed	9 unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (F	irst, Middle, Maiden Surname)
Baltimore, MID 21215-00136 permit. Pages I and 2 should be filed vinthin 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	æ	Stephen Ellis Jarvis Helen Fr	ances Simpson
2121 tould be find Mental I is marked tic event,	P	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rur	
ages I and 2 should be fill to f Health and Mental I to f Health and Mental I to f Iftem 27 is marked other traumatic event.		Stephen Jarvis/Father 653 County Road 10, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or other place)	
Itim it. Pag urtment ortant ry or o		4 Donation 5 Other Specify: Chesapeake Crem. 103.  21. Signature of Funeral Service Licensee 22. Name and Address of Facility.	Stephen D. Lohrmann,
Balt permit. Departi Import injury		21 Signature of Funeral Service Licensee MO1443  Rapp. Funeral	remarks shock or heart Approximate Interv
Physician		23a. Poil I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or infailure. List only one cause on each line.	Death
ledical aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	n
		Sequentially list conditions, b.	
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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60, ate be e hysiciar e burial	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
6876 ertifica ding ph	an/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ncy Month Day Year
Box 687, death certifics the attending ped for use as the		1 Yes 2 No 9 Unknown 9 Unknown 1 Other (Specify)	
that the d ned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown
Division of Vital Records, P.O. Into rattending Physician: The law requires that the safter death.  The share death.  The share the share signed by the share signed by the share share all pirector. After this certificate has been signed by led in the the funeral director, page 2 should be deated.	1 0		24a Was an 24b. Were autopsy findings availa
aw requested as been 2 should	l et		autopsy prior to completion of cause of performed?
<b>Rec</b> The la cate h:	Completed	26.Place of Death (Check of	1 Yes 2 No 1 Yes 2 No
Vital Rec sysician: The this certificate	Be	25. Was case referred to medical	g Home 5 Residence 6 Other:
In of Vital Records, ling Physician: The law requir After this certificate has been a	<u>ا</u>	1 V Yes 2 No  27 Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?	28d. Describe how injury occurred
ending ath. or: Af	tion	1 Natural 5 Pending Investigation Found 3/13/08 Found 9:00 am	Unknown
VISION Attendents of the design of the desig	ifica	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locating 505 tall here of the art Neces of Town, State)  silver Spring,
Spital spital neeral l	Certification:	4 House  4 House  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only 1)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcaral Director: After this certificate has been signed by the attending physician and commiscible filled in whe funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	it the time, date and place, and doctorio occupy
To t To t	Med	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		O.C.M.E.	March 15, 2008
		30. Name and address of person who completed cause of death (Item 23a)  Ana Ruhio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1
		32 Agristrar's Signature	
	State		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1 . 30 AMM 2008 Francoise J. Kantor March 15, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 F 80 064-32-3176 Director 09/11/1927 France Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Mayes 2 □ No Director MD Montgomery Garrett Park 10e Street and Number 10f Zin Code 10g Citizen of What Country? items 23a or 20896-10702 Kenilworth Ave. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ō 1 ☐ Yes 2 No Specify Specify: 3 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Higher Education than Elementary/Secondary (0-12) College (1-4or 5+) Professor 54 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Melat Charlotte (Unknown) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perint. Pages 1 and 2 s
De artment of Health ar
Important: If item 27 is
any injury or other trau Gideon Kantor/Husband 10702 Kenilworth Ave. Garrett Park, MD 20896-Kontor Fr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 20 Mar 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Park Lawn Mem. Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses M00382 Rapp Funeral & Cremation Services Tiple & Johnmann 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Taur /Medical Due to (or as a consequence of) Examiner horrizcuta Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of); Examiner The law requires that the death certificate be executed burial-transi nding physician and Due to (or as a consequence Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy atter in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 22 No has page certificate 1□ Yes Hospital or AttendIng Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Inpatient 2 ER/Outpatient 3□ DOA P After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Che ck onh 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated

State Registrar 29b. Signature and title of certif

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rel 32. Registrar's Signature

Greorgian

29d. Date signed (Month, Day, Year)

Sima Nourani Zenuz MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 20:20 PM KACZYNSKI MARCH KONALD W /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS BAYNIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Adopths | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F 68 4-8-1939 Director 212-36-4135 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Baltimore Co. MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 any Injury or other traumatic event, the Medical Examiner must be notified once. 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 7047 Eastbrook Avenue 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2□No 195 / If Yes, Give Year or Dates: 1959 2□No1957-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) N/A Highway Division Assistant Super<u>intendent</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Kaczynski Laura Sawieki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7047 Eastbrook Avenue Theresa Kaczynski - Wife Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cemetery 4 Donation 5 Dother (Specify) St Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** PNEMMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence uty Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide

To the Hospital or Attending Physiclan. The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

State

29a, Certifier

Maria

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAIN MD



Eastern Avenue

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

t√Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

Baltimore,

29d. Date signed (Month, Day, Year)

March 18, 2008

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician 2008 eora /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTI MORE TIMORE 8. Date of Birth (Month, Day, Year) Age (In yrs. [ast birthday] If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Days Months 1 M 2 □ F Hours Director Wisconsin Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No **Funeral Director** Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 2123 12. Was Decedent Ever in U.S. Armed Forces?

1 If Yes 2 □ No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc other traumatic event, the Medical Examiner should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) lonumenta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) dward 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition permit, Pages 1
Department of He
Important: If Iten
any Injury or oth Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (*Specify*) 3 Removal from State 22/08 Holly Hills Meni. 21. Signature of Funeral Service d Address of F BALTIMORE MO ZIZ34 Pel+Cremation Sorvices-Parkville Funeral (ha 23a. Part1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. immediate Cause (Final Physician VO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No this certificate or Attending Physician; 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number moon 3 G

State Registrar KJ. 16. MD 2 1234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8500

32 Registrar's Signature

Mon

muc

31. Date filed (Month, Day, Year)

MAR 21

			State of Maryla		irtment of H <i>rtificate of I</i>			_ (UUC	09132
15		-	Registrar  1. Decedent's Name (First, Middle, Last)	- 001	timeate of t	Jean	2. Date of Death	g. No.	3. Time of Death
	Physicia		Louis	<u>L</u>	anasi	9	March	Day Year	8 16:00 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	. 1	4c. County of Dea	
		. 3-	Johns Hopkins Hospital			more C	174		
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 M 2 □ F 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09-12-1	9. Bir 923 Ma1	thplace (State or Foreign ountry) yland
2	D		Usual Residence of Decedent	Cit. Town on Lo	ention				10d. Inside City Limits
	arylar show	7	10000000	City, Town or Lo					1 ☐ Yes 21 No
	the M	Director	Maryland Harford	Bel Air	10f. Zip Code		10	g. Citizen of What C	ountry?
	3a or	٥	201 Yorkshire Way #D		21014			U.S.A.	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other tran "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2X No	Specify:	, mount of one	Specific	hite
5	"natura edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done	eation during most of work d)	ing	16b. Kind of Business	/Industry
4	withir ene. than be Me	dmc	Elementary/Secondary (0-12) College (1-4or 5+)		nan Mecha			Crill Truc	king Co.
2	i filed I Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name			
0	should be and Mental marked c	To B	Michael J. Lanasa			Mary Mul	len		
	2 should be filed withir and Mental Hygiene. Is marked other than raumatic event, the Me	ľ	19a. Informant's Name/Relationship (Type. Print)  Ida V. Lanasa (wife)			and Number or Rur Way #D B		City or Town, State,	Zip Code)
ב ט	1 and 1 Health iem 27 other tr			b. Place of Dispo	sition (Name of			20c. Location - City o	r Town, State
2	ages ent of tt: If Its y or o		1 M Burial 2 Comption 2 D Romovol from State		natory or other plac 1em - Gard	ens 03-24	-2008 E	Bel Air, M	D
Jali	permit. Pages 1 and 2 Department of Health & Important: If Item 27 Is any Injury or other tra		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility Sch	imunek E		me of BelAir
_	70 E # 9		23a. Part1. Enter the disease, or complications that caused the do					Air, MD	
		0	shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Hethic 1		tant st	aph au	reus pi	neumonia	21 days
	Examiner		chronic ob	. ,	ve. rulm	nonary d	sease		30 years
	- AMA -	ner	if any, leading to immediate  Due to (or as a cons	sequence of):					
	nd new man	Examiner	that initiated events c						
00.00	cate be executed physician and	E	resulting in death) Last Due to (or as a cons	sequence or):					
	ificate be executed g physician and as the burial-transit	dical	d						
<b>Y</b> 00	nding use a	n/Me	IF FEMALE: 23c. If yes, outcome pf pre 23b. Was decedent pregnant		7e			23d. Date of d	elivery
5	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	200. Was december pregnant   1		□Ectopic pregnanc □ Other <i>(specify)</i> _	у		Month	Day Year
	that the ed by detac		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
color,	quires in sign uld be	ed by	aortic stenosis				1 DX/Y6	es 2∐No 3∐I	Probably 4 □Unknown
מט	law re as bee	Completed	endocarditis				24a. Was ai	n 24b. Were	autopsy findings available completion of cause of
ב ה	: The cate h	Con					perforr 1□ Yes 2	neel? death? 2. A No 1 □ Ye	s 2 No
VII	iclan certifi ector	Be	25. Was case referred to medical examiner?  Hospital: Mospital: Mo		ot 3 DOA Oth	ner:	th Check onl on		
5	Phys er this eral di	<u>ا</u>	27. Manner of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time o	" OLI DOX	4 🗆 Nursing no		ence 6 □Other (Sp ow injury occurred	ecity)
	nding tth. r: Afte e fune	ation	1 X Natural 5 □ Pending (Month, Day Year 2 □ Accident investigation	r) Injury		rk?  Yes 2 □ No			
2	or Atte fter dea frecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp.	t home, farm, streecify)	reet, factory, office		28f. Location (St City or Town	reet and Number or i n, State)	Rural Route Number,
3	spltal ours at seral C		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, dea	th occurred at the ti	ime, date and place	, and due to the c	ause(s) and manner	as stated.
	n 24 ha	Medical	(Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.						
	To the To the Complex	ğ	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Mo.	
			Dan Neum Lanshur, Medica				= 0-1/1	larch, 19,	
	12		30. Name and address of person who completed cause of death ( Dara Neuman-Sunshine, Johns Hopk  33. Registros Si	Item 23a) (Type,	Print)	ath was le a	treet o	il somitte	aculand DIDE
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature	41,600 NO	IM WOITE 3	Theel BC	LITHINGE, M	arylany alao
	Registi		MAD 2 1 2008	Je .	Paril .				

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Me	ental Hyg	iene		00100
		•	1 - State Certificate of Death	Re	eg. No. 2 U	1 U 8	09133
js.	Dhyoloir		1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day	Year	3. Time of Death
	Physicia /Medic		Daniel Craig Lemaster	03-	17-2008		08:59P <sup>M</sup>
i	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County		-
.: See	(4)		Heritage Harbor RehabilitationCenter Annapolis  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		Arund	le⊥ lace (State or Foreign
	Funeral Director		213-52-4306 12M 2 F 57 Yrs. Months Days Hours Min.	(Month, Day, 11-14-	Year)	Coun	MD
, Sales	The see was some	ļ	Usual Residence of Decedent		1750		
	ırylan show 1 at	_	10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ne Ma 8a-f s atifier	ecto	MD Anne Arundel Glen Burnie		0.000	14/11-0	
	with the	Ö	10e. Street and Number  117 Alview Terrace  10f. Zip Code 21060	1	0g. Citizen of	wnat Coun	try :
	eath is 23	eral		cifv Yes or No-	U.S.A.	ce - Americ	an Indian,
õ	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item Z? is marked other than "natural", or items 23a or 28a-f show if item Z? is marked other than "natural", or items 2 as or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F  1 □ Never Married 2 □ Married If Yes 2 □ No  If Yes Give 1 □ Yes 2 □ No Specify:	Rican, etc.)		ck, White, o fy: whi	
0000-	hours tural	ed by	3 ☐ Wildowed 4 ☑ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of B		
<u>.</u>	nin 72 n "na Medic	Completed	(Specify only highest grade completed)  [Give kind of work done during most of working life. DO NOT use retired]  [Give kind of work done during most of working life. DO NOT use retired]	ng			
7	d with giene er tha the l	mo;	12 Truck Driver		Deliv	ery	
מום	al Hyle l othe vent,	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, I	Maiden Surnai	me)	
<u>8</u>	should be ind Mental marked c	70	Gifford Lemaster Margaret				
<u> </u>	2 short and rism		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura				Code)
	1 and Health em 27 ther tr		Mrs. Christina Allen / daughter 502 E. Jeffrey St; Balt 20a. Method of Disposition 20b. Place of Disposition (Name of	ate	20c. Location		wn, State
5	ages int of t; If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	2008		•	
pallimore	permit. Pages 1 an Department of Heal Important; If item 2 any Injury or other once.		4 □ Donation 5 □ Other (Specify) Maryland Vets. Cemet. U3-20  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sin				
Ď	Depar Impor any Ir		Moi357 1 2nd Ave SW; Glen I				
			23a. Part1. Ever the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or hard failure. List only one cause on each line.	r respiratory arr	rest,		Approximate Interval Between
	Physician		disease of condition	ance.	r		Onset and Death  2   Conset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		er	Sequentially list conditions, if any leading to immediate.  Due to (or as a consequence of):				
1	uted d ansit	Examiner	Sequentially list conditions,				
Ć	an andrial-tra	Еха	resulting in death) Last  Due to (or as a consequence of):				
2/00/0	certificate be executed iding physician and ise as the burial-transit	lical	d				
ŏ		Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy		00.1.5		
POX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	in the past 12 months?			ate of delive onth	Day Year
	iaw requires that the death as been signed by the atter 2 should be detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
, ,	s that ned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use cor	ntribute to th	ne cause of death?
coras	equire en sig ruld br			1 XY	es 2 No	3 ☐ Prob	pably 4 □Unknown
	2 13	Completed		24a. Was a		Were auto	psy findings available mpletion of cause of
<u> </u>	sician: The law s certificate has b lirector, page 2 s	Com		perfor 1⊟ Yes	med? 212 No	death? 1 ☐ Yes	2 □ No
710	ician; sertific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital: Other: O				
0	Physician; this certific ral director,	٦.	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hor	me 5 Resid			y)
SION	ding h. After	tion	27. Manner of Death  1 ★ Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 4 Work?  2 □ Accident investigation  M 1 □ Yes 2 □ No		,,		
2	I or Attending after death. Director: After I in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office	28f. Location (S City or Tow		ber or Rura	al Route Number,
5	s after al Direction	Certification	4 ☐ Homicide building, etc. (Specify)	City of Yow	n, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  One	and due to the d ed at the time, d	cause(s) and m date and place	nanner as s , and due t	tated. the cause(s)
	Fo the within 2 Fo the сотрые	Med	29b. Signature and title of certifier 29c. License number	2	29d. Date sign	ed (Month,	Day, Year)
	r> = 0		1 / and 12eney MD 0002957	7/	03/	18/	2008
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	14 (	rof	ton	, MOZILLY
	Sta		29a. Certifier  (Check only one)  2	//	1		
	Registr	ar	WILL N I LOOP SERVINGS IS MANUEL				

			For State	State of Marylar		rtment of <i>tificate o</i>				2008	09134
	-	1/4	Registrar     Decedent's Name (First, Middle, Land)	ast)	061	incate c	n Dealli	2. Date of De			3. Time of Death
1	Physici /Medic		JOAN L	uecking				Month MAR	CH 1	8, 2 <sup>Year</sup>	8 10:31AM
	Examin	1110	4a. Facility Name (If not institution, gi	ve street and number)	nter	4b. City, Town	n, or Location of Death Tows		4c. C	ounty of Deal	timore
	Funeral Director		217-30-3480	Sex 7. Age ( <i>In yrs.</i>		If Under 1 Ye Months Da		8. Date of Bir (Month, Da	th y, Year) 7, 1924	9. Birt	hplace (State or Foreign
and	w 1		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loc	ation					10d. Inside City Limits
Mary	-f sho fied a	tor	MD Buth	mare	Catons	ville					1 ☐ Yes 2 ☐ No
th the	or 28g	Director	10e. Street and Number			10f. Zip Cod			10g. Citize	n of What Co	puntry?
w the	s 23a nust b	iral	102 Fart	12. Was Decedent Ever in U	10 10 10		228			S. A. I. Race - Ame	rican Indian
:1 Z15-0036 within 72 bours after death with the Marvland	ul Hygiene. other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in C Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If	Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puerl No <i>Specify</i> :	o Rican, etc.)	i	Black, Whit	
5-0036	natura dical E	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Deced	ent's Usual Oc	cupation ne during most of wor	rkina	16b. Kind	of Business/	Industry
<b>12</b>	than "	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ONOT use re	ne during most of wor tired)		1/4	20	
N 2	Hygi other	e Co	17. Father's Name (First, Middle, Las	1)	1 /4	ZGISKK.	18. Mother's Nan	ne (First, Middle	Maiden S	urname)	
arylan should be	₩ <b>' ' ' ' ' ' ' ' ' '</b>	To B	Thomas K. S.	haughness			ANN	a Ga	VNON	/	
Maryland d2 should be file	h and 7 Is mg		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing	g Address (Str	eet and Number or Ru	ıral Route Numb	er, City or	Town, State,	Zip Code)
	item 2 other		JoSe DK Luck, 20a. Method of Disposition	1Ng - JON 20b.	Place of Dispos	sition (Name of	va Rd., L	Date Date	20c. Loca	ation - City or	Town, State
	5 ± 5		1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		cemetery, cirem 10 d Lawn	//	/	4-2008	h love	Laida	( M)
Baltimore,	Departmen Important: any injury once.		21. Signature of Funeral Service Lice			Name and Ad	Idress of Facility	radley -	ASK	FON FO	NERAL HEME
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the dea	th. Do not ente		dying, such as cardiac			d di	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)	_a. ASCVD							Onset and Death CHRONIC
	Medical xaminer			Due to (or as a consec	quence of):						4 WEEKS
0	# # #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						,
ecute	and -	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ATRIAL FI		NOITE					4 WEEKS
58750, ficate be ex	physician and the burial-transit	edical E		VOMITING		SPIRAT	ION				1 HOUR
ertifica	ling ph e as th	Med	IF FEMALE:	00-16							
ords, P.O. Box 68/60, requires that the death certificate be executed	by the attending platached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes No	23c. If yes, outcome pf pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3 🗌	Ectopic pregna Other (specify			23	d. Date of de Month	Day Year
S, F	s been signed b	by Pr	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause	given in Part I.				the cause of death?
ecords,	Deen s	eted						1 🗆			robably 4 Unknown
r e	8 0	Completed							ormed?	death?	utopsy findings available completion of cause of
	ertifical ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea	1  Yes ath (Check only o	2 <b>2</b> No   one)	1 □ Yes	2 <b>X</b> No
_	, .g p	ဥ	1 Yes 2√ No		R/Outpatient	3 DOA		lome 5 ☐ Resi			cify)
ding F	After funera	tion:	27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work? 1 □ Yes 2 □ No	28d. Describe	how injury	occurred	
UIVISION I or Attending	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not I 4 Homicide determine	De 290 Place of injury. At h	lome, farm, stre			28f. Location ( City or To		Number or R	ural Route Number,
Hospita	Funeral Funeral	Medical C	29a. Certifier 1 Certifying P	hysiclan: To the best of my knuminer: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at th	e time, date and place ny opinion, death occ	e, and due to the urred at the time	cause(s) a	and manner a: place, and du	s stated. e to the cause(s)
To the	vithin Fo the	Med	29b. Signature and title of certifler	and marmer stated.		29c. Lic	ense number		29d. Date	signed (Moni	th, Day, Year)
			1			D6	<b>2005</b>		3	19/08	
	10		30. Name and address of person who						men and 4 -		
	Sta	te		AND I NGHAM M 32, Registrar's Sign	D. 76	01 09	LER DRIV	E, TOW	SON.	MARY	_AND 21204
	Registr	- 10	31. Date filed (Month, Day, Year).	2008 32 Registrar's Sign	15 /40	Dell.					

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State 6		artment of Health and l <i>rtificate of Death</i>	-	jiene leg. No. 2008	09135
Physic	ian	Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
/Medi	cal	MARCHET ANN LE  4a. Facility Name (If not institution, give street and no	WTZ (mbor)	4b. City, Town, or Location of Deatl	03-	19-2009 4c. County of Deat	
Exami	ner	600 Straffan Drive #101	amoery	Timonium		Baltimo	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	9. Birt	thplace (State or Foreign
Director		213-28-5400 Usual Residence of Decedent	70 715.		03-23-1	.931   Mai	ryland
aryland show	_	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2 No
the Ma 28a-f	Director	MD Baltimore  10e. Street and Number	Timonium	10f. Zip Code		10g. Citizen of What Co	
th with 23a or		600 Straffan Drive, #1	01	21093		USA	
tems ter mu	Funeral	Armed F	cedent Ever in U.S. 13. forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
d 21215-0036  filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, 0 Year or	2 🔀 No live Dates:	1 ☐ Yes 2 【 No Specify:		Specify:	White
5-0036 72 hours at natural", or dical Exam	eted	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	16b. Kind of Business/	Industry
within ene.	Completed	Elementary/Secondary (0-12) College	(1-40r 5+)	Business Owner		Retail	
- 0 - 0 9	Be Co	17. Father's Name (First, Middle, Last)	, ,	1	me (First, Middle,	Maiden Surname)	
	To E	Raymond J. Boulay			M. Peter		
and 2 sh and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship (Type. Print)  Catherine L. Cowley/Dau		ng Address <i>(Street and Number or Ri</i> 20 <b>Symphony Cr.</b> ,		, . ,	
of Fig.		20a. Method of Disposition	20h Place of Dieno	peition (Name of	Date	20c. Location - City or	
altimore, mit. Pages 1 ar partment of Hez portant: If Item y Injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Corporati	on	24-2008	Towson, M	aryland
Baltimo permit. Page Department of Important: If any Injury or once.		21. Signature of Foreral Service Licensee			Ruck Tows	on Funeral	Home, Inc.
3.43		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ent each line.	ter the mode of dying, such as cardia	c or respiratory are	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ronic Obstruc	thre Pulmonary	Diseas	e	> Syears
Examiner	ı		o (or as a consequence of):				
1.52 %	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of).				
68760, (finate be executed physician and streets the burial-transit is the burial-transit	Examiner	that initiated events C.	o (or as a consequence of):				
68760, ficate be ex physician is the burial	edical E	d			· · · · · · · · · · · · · · · · · · ·		
x 68 ertifica ling ph e as th	Medi	IF FEMALE:					
Hecords, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and lagge 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
P.O.	hysi	1 ☐ Yes 2 TMNo 9 ☐ Unknown 9 ☐ Unk	nown		1		
IS, F	by	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		obacco use contribute to	o the cause of death? robably 4 □Unknown
cord; w require been sign	Completed				24a. Was a		utopsy findings available
	omp				autop perfor 1□ Yes	sy prior to rmed? death?	completion of cause of
Vital Records, stclan: The law requires to certificate has been signed inector, page 2 should be or	Be	25. Was case referred to medical examiner?		Louber	ath (Check only or	ne)	
Physic ruthis or all directions	. To	27. Manner of Death 28a. Dat	Inpatient 2 ER/Outpatier e of Injury 28b. Time o		1	lence 6 Other (Spe	ecify)
ath. or: Afte	ation	2 Accident investigation	onth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
DIVISION OF  I or Attending Phys after death. Director: After this Lin by the funeral di	Certification:		ce of injury - At home, farm, str ding, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
DIVISION OF VITAI  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, to				th occurred at the time, date and plac			
the Ho hin 24 the Fu	Medical	one) and ma	inner stated.	29c. License number			` ` `
<b>7</b> ₩.	4	29b. Signature and title of certifier  Pelmak l. Tran	un ind	D52496		29d. Date signed (Moni	2008
10		30. Name and address of person who completed ca	use of death (Item 23a) (Type,		C 111	mulle mi	)
1	ato	DEBORAH A. FRASSICA 31. Date filed (Month, Day, Year)	Registrar's Signature	talls Kd Steig	s, Luft	DEL ACTUELLA P	,
Regist	ate rar	MAR 2 1 2008	Registrar's Signature	dis			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** March 17, 11:50 A M Leonard Benjamin Lamoon Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Aberdeen 31 Valley Bottom Road ADCLUCCI. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 10, 1947 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F Maryland 60 Director 218-46-9267 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No notified Directo Maryland Aberdeen Harford 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ns 23a or must be n death with 21001 USA 31 Valley Bottom Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 4 Z Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Iron Worker Steel Fabrication 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Lewis Benjamin Harrison Lamoon Sr. ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i Lutisha M. Felizzola / Daughter 1711 Pulaski Highway, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-22-08 Hilltop Service Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature of Funeral Service Cica see 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death bal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complete shock, or heart failure. List only the arteriosclerotes Cardio Vincolar Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ※ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

within 24 hours after death

To the Funeral Director;
completely filled in by the

LA MOON, LEONARD 3/12/08

State Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

BERNARD YUKWA MD.

31. Date filed (Month, Day, Year) MAR 2 1 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1614 CHYRCH VILLE Ad BEL AIR Md 21015

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 18, 2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 1012 0 09 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner p, ta Atlantic Worces energ 705 -liN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 ☐ M 2 🔀 F Yrs. Director 213-12-0010 86 Oct. 19, 1921 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show item 27 is marked other than "natural", or items 23a or 28e-f sho other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Delaware Director Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37140 Sugar Hill Way by Funerai 19975 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No 3. Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Anne Arundel School Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Manager Board 7/2008 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked other Frank Julian Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Miller (Son) 14200 Lighthouse Ave., Ocean City, MD 21842 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery | 3/12/08 Baltimore, Maryland 9 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLoudon Park Funeral Home DO 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part I. Enter the isease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Hypoxic Kepirato /Medical Examiner Monas Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine verman! tor: After this certificete hes been signed by the attending physicien and the funeral director, page 2 should be detached for use as the burial-trar Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably A Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No nemia 1 ☐ Yes 25. Was case referred to medical examiner? 26. Pface of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Innatient Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 Tes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by efter 4 Homicide within 24 hours e To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

10/19/19/2

ress of perion who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year MORTON 2008 MAN MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Famility Name (If not institution reive street and number) 4b. City, Town, o. L.

BALTI MORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth, (Month, Day, 1997) | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 199 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 214-20-766 1**X** M 2□ F Director IRGINIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 3 SA, Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 Nes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕰 No Specify: Specify: ð 3 ☐ Widowed 4 ⚠ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NOER WORK SELF-EMPLO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE RTO, traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. ELORES Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State FOREST 03-21-08 DWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BROWN TR. FUNERAL HOME 21. Si nature o Funeral Service Licenses BALTO, MD 2121 2140 FULTON N 23a Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sorck, or art failure. List only one cause on each line. Approximate Interval Between Onset and Death I rime iate C re (Final lesse or condition resulting in death) UA3Cular Physician Lerotic 1 evo SC eau /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Quality for such consequence offi-The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Yea 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by OCANDIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ostridin( 2 No or Vital Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗆 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (m) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bolto Md 21206 Bm ( 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** 8-41PM 18 2008 Eduard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Medical ente Baltimor e 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. NA Months Hours 1 □ M 2 □ F Director MD 110 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21217 2348 Eutaw Place Apt 3 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tamika White Thomas Monroe ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2348 Eutaw Place Apt 3, Baltimore, Md 21217 Thomas Monroe-Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc 3/21/08 Baltimore, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
March F/H West Signa we of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, 23a. Pa / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mme late Cause (Final Due to (or as a consequence of): **Physician** Extreme resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner W Due burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year detached for in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page ; 2 No certificate 1 ☐ Yes 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Nnpatient Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital

State Registrar

5 SHIV 31. Date filed (Month, Day, Year)

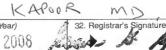
0

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neonatologist, Mercy Medical Center, Bultimon 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 50775

29d. Date signed (Month, Day, Year)

03/18/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 Physician DMRoland March 18. 5:00 C. Murphy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Months Days 1 □ M 2XX Director 217-16-4298 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Expriner must be notified **Funeral Director** 1 ☐ Yes 2 🔀 No Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2525 Pot Spring Road Apt. K501 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4 Divorced Year or Dates: **WWII** White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Federal Government <u>Transportation Analyst</u> s 1 and 2 should be filed with Health and Mental Hygie Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. Murphy Henrietta Cole ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Rd. Apt. K501 Timonium, Md. 21093 Mrs. Mary V. Murphy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 3/22/08 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PROSTATE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entry Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2□ Fetal death
□ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 ☐ Yes 2 X No 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) al or Attending P s after death. I Director; After t 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Hospital within 24 hours a

2008

ROLAND MURPHY

State Registrar

TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year) 9108

Registrar's Signature

and manner stated

		Please	Type or Prin							9	
		For State Registrar	State of Ma	ryland		artment of I <i>rtificate of</i>		nd Mental H	ygien Reg. No	7111118	09141
	71	1. Decedent's Name (First, Middle, La	st)					2. Date of [			3. Time of Death
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/Medic Examin		4a. Facility Name (If not institution, giv		•	11000	4b. City, Town, o	or Location of	MAR(		8. 2008   c. County of Death	10:41F
		Saint Joseph	Medical	Cent	en		То	wson	ĺ	Balti	mare
Funeral		5. Social Security Number 6. S		(In yrs. las		If Under 1 Year Months Days		Hrs. 8. Date of E	Day, Year	9. Birthplac	ce (State or Foreign
Director	0	219-18-7905 Usual Residence of Decedent		83	110.			Aug.	17,19	924   Mary	land
ylan ylan		10a. State 10b. County		10c. City,	Town or Lo	cation				10d	. Inside City Limits
Mar A-f st	ţ	Maryland Baltim	ore	To	owson						1 □ Yes 2 🛣 No
r 28	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Country	1?
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deati ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13.			n? (Specify Yes or N Puerto Rican, etc.)	No-	14. Race - American	
ifter of the plane	큔	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 N If Yes, Give	0				Puerto Rican, etc.)	}	Black, White, etc	<b>.</b>
urs a al', o	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1⊡Yes 2⊠No	Specify:			Specify: White	ρ
2 ho	ted	15. Decedent's Ed			16a. Dece	dent's Usual Occu	pation	of secondaria	16b. H	Kind of Business/Indus	-
e. Med "r	ple	(Specify only highest gra		+)		kind of work done DO NOT use retire			10		
be filed within 72 hours after death with the Maryland tall Hygiene. A powrs after death with the Maryland of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed		College (1-4or 5- 5+		Direc	ctor of G	eneral	Services	_  S.	tate of Mar	ryland
othe othe	Be C	17. Father's Name (First, Middle, Last,	)				18. Mother's	s Name <i>(First, Midd</i>	lle, Maide	n Surname)	
Ald by Alenta	10	John Edi	mund Mo	Garry	, Sr.			Margare	t	Hady	
should Ind Men		19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route Nun	nber, City	or Town, State, Zip C	ode)
and 2 ealth a n 27 is		Nina McGarry	Wife		1627	7 Jeffers	Road	Towson,	Mary	vland 212	04
s 1 a		20a. Method of Disposition		20b. Plac		sition (Name of matory or other pla		Date		ocation - City or Town	
permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Monee.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif					1	-20-2008	To	owson Ma	aryland
permit. Depart Import any inj		21. Signature of Foreral Service Licer	nsee			2. Name and Addr 1050 York	•	Ruck Tow Towson,		Funeral Ho vland 212	
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/Medical		disease or condition resulting in death)	a. SEPSIS  Due to (or as a	consegue	nce of):			- 1			
Examiner			,		,	REATIC	CANCE	D			
	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a			KEHIIL	CHINCE	rx			
executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury									
exect al-tra	Xa	resulting in death) Last	C Due to (or as a	conseque	nce of):						
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phy:	ğ		-0.								
The law requires that the death certificate be tee has been signed by the attending physicis bage 2 should be detached for use as the bu	Physician/Medica	IF FEMALE:	23c. If yes, outcome p	of pregnance	ev					23d. Date of delivery	
eath cer attendin for use	Siar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐Pregnant at	2 Fetal d	eath 3	Ectopic pregnanc Other (specify) _	y		ŀ	Month Da	
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w require been signature should b	Completed							_			
e 2 s	힏	RENAL FAILURE						24a. Wa	tonsy	nrior to comp	y findings available letion of cause of
	ပ္ပြဲ							1  Yes	rformed?	death? o 1 ☐ Yes 2	□No
Physician: Th	Be	25. Was case referred to medical examiner?	119-1					f Death (Check only	one)		
(1)	၉	1 ☐ Yes 2 X No	Hospital: 1 Inpatier	-		IL OLI DOA		ing Home 5□ Re	sidence	6 ☐Other (Specify)	
ng P ifter (	ä	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		8b. Time of Injury	f 28c. Inju Wo	ry at rk?	28d. Describ	e how inju	ury occurred	
Attending r death. ector: After by the funer	äŧ	2 Accident investigation					Yes 2 □ No				
r Att er de Fect	ŭ∥	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At hom. . (Specify)	e, farm, str	eet, factory, office			(Street a	nd Number or Rural F	Route Number,
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5 ⊃ 15		29a. Certifier 1 Certifying Ph	nysician: To the best o	f my knowle	edge, deat	h occurred at the t	ime, date and	place, and due to the	ne cause(s	s) and manner as stated	ed.
or unit	g	(Check only 2 Medical Example 1	miner: (In the hacle of		TO SECURE OF THE		VERNORI, UDALI	, cocumen at the tim	o, uate ar	is place, and due to th	io vause(s)
he Hospital or Attending Phy in 24 hours after death. the Funeral Director. After this pletely filled in by the funeral d	edical	one)	and manner sta	ted.							
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State

Registrar DHMH 17 Rev 1/2001 DRIVE TOWSON, MARYLAND 21204

		State of Marylar  1- State Registrar	nd / Dep		lealth and I			gible.	0011.2	
Physicia /Medica		1. Decedent's Name (First, Middle, Last)				2. Date of D	2. Date of Death 3. Time of Death			
		Mary Marjorie McBrid		e			Mar 17, 2008		3:35 A <sup>M</sup>	
, Exami	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death Fulton	1	4c. Cou	nty of Death	oward	
Funeral		11.19 ()			If Under 1 Year   If Under 24 Hrs.   8, Date			e of Birth 9. Birthplace (State or Foreign Country)		
Director		220-38-8404 1 M 275 F 8	monute Buye				Jun 23, 1924			
yland yland			ty, Town or Lo	ocation				1	0d. Inside City Limits	
ie Mar 8a-f st	Director	MD Howard			Clarksville	<b>.</b>			1   Yes 2   10	
of after death with the Maryland or items 23a or 28a-f show miner must be notified at		10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cour	ntry?	
death ms 23	Funeral	6485 S. Trotter Rd. 11. Marital Status 12. Was Decedent Ever in U	.S. 13.	Was Decedent of H	21029 Ispanic Origin? (S	pecity Yes or N	o- 14. F	U.S ace - Americ		
after or itel		Armed Forces?  1 ☐ Yes, Qive		13. Was Decedent of Hispanic Origin? (Specity If Yes, specity Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☐ No Specify:			n, etc.)  Black, White, etc.  Specify:			
ITIO Z IZ ID-0030 be filed within 72 hours af tal Hygiene. d other than "natural"; or event, the Medical Exam	d by	Year or Dates:						VV	hite	
nin 72 ni 'nal	plete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Dece   (Give   life.	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of wor d)	king	16b. Kind of	Business/In-	dustry	
d with signal with signal with a signal with	Completed						Healthcare			
be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle	e, Maiden Surn	ame)		
ite, INIAI yilailid ZIZIO-UUJO s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	2	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street	her City or Toy	City or Town, State, Zip Code)					
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Definition Pages Department of I mportant: If it in Injury or o		4 □ Donation 5 □ Other (Specify)	Mt. Zion	United Metho	dist 3-2	0-08	ŀ	lighland	, Maryland	
Deartiming in the permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral/Sorvice-troensee	129R 2	2. Name and Addres	uneral Home	, P.A <u>.</u>				
		23a. Part1. Life discrete, or complications that crused the deal shock, or heart failure. List only one cause on each line.	th. Do not en	ter the mode of dyin	ld Columbia F g, such as cardiac	or respiratory	arrest,	1043	Approximate Interval Between	
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aw req	lete					24a. Was	24a. Was an autopsy available prior to completion of cause of death?  1			
The la ate ha	Completed									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be C	25. Was case referred to medical examiner?  26. Place of Death (Check only one)								
	: To	1 Yes 2 No Hospital: 1 Inpatient 2 EF/Outpatient 3 DOA Other  27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury.				sing Home 5 Residence 6 Stather (Specify) gray home				
nding th. :: Afte e fune	Certification:	1 ☑ Matural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No				zod. Describe	1. Describe now injury occurred			
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e Hosp 24 hou Frune etely fi	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the within To the comple	Me	29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year)			
		I (carles Mg	P-53636			March 17, 2008				
.)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
	ta	31. Date filed (Month, Day, Year) Dec. Registrar's Signal	har the	Drive C	Mushed	MO	21044			
Sta Registr		MAR 2 1 2008	1500	de l'						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 15, Day 2008 Year 6:30a **Physician** Neighoff, Sr. Thomas Raymond /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's Charlotte Hall Veterans Home Charlotte Hall | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug | 14 , 1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral X** M 2□ F Maryland 86 215-18-5302 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Linthicum Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21090 229 Homewood Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 译Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Carpenter permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If Item 27 is marked other the any Injury or other traumatic event. \*\* 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Marie Schifley Thomas Jacob Neighoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 229 Homewood Rd., Linthicum, MD 21090 Esther L. Neighoff (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/18/08 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Pa ... Enter the fleese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIORGAN /Medical Due to (or as a consequence of): **Examiner** 1POTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine JUAC ARTERY ANGURYST attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No cate has been signed by the page 2 should be detached 9□Unknown 9 T I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred after death. 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHANI 2NIN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mor

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ne SOM 2008 TRORGE la /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number), 4b. City, Town, or Location of Death **Examiner** Baltimore 70501 LOWSON If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days 219-30-5395 Usual Residence of Decedent **Director** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show "natural", or items 23a or 28a-f shov edical Examlner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4.5. 21014 Ea death 1 Funeral Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: KORCA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 No þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 Innent of Health and Mental Hygiene. 2121 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the once. Ichrician Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ DENJamin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson 21014 oa Baltimore, 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-20-08 DWINGS MUlls, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility -ASKEN FUNERAL Spring Rd. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 212 emente /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No After this certificate or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAN J CHYMUS W 6701 N. Chy 2+ Charles St TON SON MO 21204 N. 6701 J CHMMES 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

March 17,200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 15 per fb 9877 3-26-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** EDWARD CHARLES NOVAK MARCH 2008 5:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST CENTER @GBMC TOWSON 8. Date of Birth (Month, Day, YADr. 13, 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Year Months Days Hours Min 1 XM 2 □ F 65 1942 Director 076-32-6345 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Harford Churchville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 7 3207 Cool Branch Road 21028 USA Funeral raf", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married aftimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public Education <del>-8-</del> Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Thomas Novak Ellen Marie McKenna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Arlene Louise Novak / Wife 3207 Cool Branch Road, Churchville, MD 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages '
Department of H
important: if ite
any injury or ot
once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Darlington Cemetery | 3-20-08 Darlington, Maryland 21. Signature of Fungral Service Licensee 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Immediate Cause (Final CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 1□ Yes To the Hospitai or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. C. Ley GBMC 6701 N. Charles St. Balto. Md 2,20 & 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Henry Martin O'Sullivan 2008 March 20. 10:44am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fairhaven Health Care Center Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, 9. Birthplace (State or Foreign Country)
NY Social Security Number 7. Age (In yrs. last birthday, **Funeral** 063-53-5390 91 March 6,1917 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at MD Carroll Sykesville 1X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 7200 Third Avenue 21784 USA Funeral 'natural', or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) +2 College (1-4or 5+) Elementary/Secondary (0-12) Credit union Manager Fianace Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry O'Sullivan Jane Frances Nee Eaton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harry O'Sullivan (Son) 308 Neale Court, Sykesville, MD 21784 item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State All County Cremation 3-21-08 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) PO Box 195 Sykesville, MD 21 re of Funeral Service Licensee MO1314 poheuta Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician e mento disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide

the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Division or Vital Records, P.O. Box 68760 attending p for use as signed by to d be detach certificate has I rector, page 2 s this After

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the I

Medical

State Registrar

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (A

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No.  2 0 0 8	0914
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year	Time of Death
Medical Examiner	Kevin P. Perkey  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	2337 NIS
	108 Riddle Drive Aberdeen Harford	
Funeral Director	5. Social Security Number 219-86-7261 6. Sex $\chi_{M}$ 2 F 43 $\chi_{rs}$ 6. Sex $\chi_{rs}$ 7. Age (In yrs. last birthday) 43 $\chi_{rs}$ 1f Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplate Country Months Days Hours Min. Jan. 6, 1965	MD
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10c	d. Inside City Limits
Aaryland 28a-f show any 1 at once. ector	MD Harford Aberdeen 1	Yes 2 X No
the y		
er death with or items 23 r must be no Funeral	11. Marital Status 1 Never Married 2 Married 2 No Specify Yes or No- 1 Never Married 2 No No Specify Yes 2 No Specify:  12. Was Decedent Ever in U.S. Armed Forces? 1 No Yes 2 No Specify: 11. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.	
urs afte tural"; aminer	3 Widowed 4 Divorced If Yas, Give Year 1 Yes 2 X No specify: Specify: Wnlt 1 1. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Indu	
5-0036 ed within 72 hours afti tygiene. other than "natural" the Medical Examine Completed by	during most of working life. DO NOT use retired)  Field Operations Manager Construct	ion
5-00 led with tygiene other in		
121! d be fill lental I. narked event, i	Calvin Perkey Judy Caswell  19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig	o Code)
AD 21 2 should 1 and Me 27 is man matic ev	Calvin Perkey /father 232 Temple Drive Belair MD 21015	o code)
re, N I and I Health fitem er trau	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Tow crematory or other place)	vn, State
imo Pages ment of tant: I	Bayview Crematory 3/19/08 Baltimore	MD
Balt permit. Depart Impor	21. Signature of Funeral Service Licensee  22. Name and Address of Facility 300 Mace Ave. Balto	. MD
Physician	20d. Fait I. Eiter the disease of an phodulone that seeded the asset is a seed to a seed to a seed the asset is a seed to a seed to a seed the asset is a seed to a seed to a seed the asset is a seed to a seed to a seed the asset is a seed to a se	Approximate Interval Between Onset and
/Medical	Immediate Cause (Final disease a. Contact Gunshot Wound of Head	Death
Adminion .	or condition resulting in death)  Due to (or as a consequence of):	
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urted ransit	events resulting in death) Last Due to (or as a consequence of):  d.	
60, nte be execut hysician and e burial - tra	X unpended	
Division of Vital Records, P.O. Box 68760, fital or Attending Physician: The law requires that the death certificate be executed are after death.  The law is sentificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit ertification: To Be Completed by Physician/Medical Executions.	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day	Year
h. Box 687( the death certification of the attending please as the Physician/N	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)	
P.O. Es that the greed by the detached by Phr		
IS, P quires t an signi	1 Yes 2 ✔ No 3 Probab	sy findings available
Records, The law requires are has been signage 2 should be ompleted	autopsy prior to com performed? death?	pletion of cause of
Vital Reconsystein: The law this certificate has I director, page 2 s.	25 Man each referred to modified 26 Place of Death (Check only one)	2 No
Vital ysician his cert directo	examiner? Hospital:   Hospital:   FEI/Outpetiest 2 DOA Other; Nursing Home 5 Pesidence 6 Other; S	cene
n of ling Ph	27. Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Describe how injury occurred	
Sior Attend r death ector: by the	Pending Investigation   3/17/08   11:20 pm   1 Yes 2 \times No   Subject shot self   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Number or Rural	Route Number, City
Division c - Division c spital or Attending nours after death. meral Director: Aft filled in by the fun Certification:	3 XX suicide 6 Could not be determined (Specify) Mobile Home or Town, State)  108 Riddle Dr., Aberdeen	, MD
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ei		ause(s)
Me Service		, Day, Year)
	March 18, 2008	
\$	30. Nam and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	6711 12 11 11 21 21 2 200 250 de 200 2	
DHMH 17 Rev 1/2001		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:55 am March 18 2008 Pinkney Melvin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Agnes HOSpital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□F 67 Yrs. **b**5 213-38-6717 40 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location X□Yes 2□No MD Baltimore Director NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 3502 Dennlyn Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 🔀 No Specify. ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housing Maintenance 8th grade Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline A. Craiq James S. Pinkney Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3502 Dennlyn Road, Baltimore, 21215 Erma Pinkney-Sister Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Mag Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Woodlawn 3/22/08 Baltimore Co, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West eky 1) 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the Usease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Lilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vanconyun resistant enterococcal backeremia
Due to (or as a consequence of): **Physician** days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ due to hepatitis 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Stage renal disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital 28a. Date of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours at er death To the Funeral Director 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Eyad

Alsheikh

MAR 2 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

900

34. Registrar's Signature

The law requires that the death certificate be executed

Box 68760

Division or Vital Records, P.O.

DHMH 17 Rev 1/2001

29c. License number P 20 966 March, 18, 2008

Caton Ave, Bultimore, MD, ZIZZ9

State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** -4/VIa MARCH 18 2008 1:40 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RIDERWOOD RETIREMENT CENTER SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/07/1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 218-03-9621 90 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Exercitar must be notified at MD 1 ☐ Yes 2 No BALTIMORE BALTIMORE **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 129 CLARENDON AVENUE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 1 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Completed by Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be NATHAN SNYDER SARA WEINBERG ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Health and Important: If Item 27 is n sny injury or other traun 8738 EAST ROWEL ROAD, SCOTTSDALE, AZ JEFFREY PITT / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State BETH TFILOH CONG. 03/20/2008 BALTIMORE, MD 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of Funerall Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Immediate Cause (Final **Physician** heart failure congestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner atherosclerotic coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit Physician: The law requires that the death certificate be executed renal ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an anemia hes per tension this certificete pulmonary 2 🗹 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Fafter death. After 1 ☑Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funersi D 29a. Certifier cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/18/2008 Fachille aleyion MD D44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd Silver Spring achelle Alexion 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 2 1 2008 doarde Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per md 8877 3-21-08 vt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Beverly Fearn Porter Month **Physician** 3 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia **Howard County General Hospital** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months | Days 1 □ M 2 X F Yrs. Director 143-28-8964 Aug 11, 1935 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show at permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified is Director Columbia MD Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21044 11029 Wood Elves Way Funeral 12. Was Decedent/Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Science Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lily Tompkins ပ Walter Fearn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11029 Wood Elves Way Columbia, MD 21044 Elsa Ponce 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Mar 18, 2008 4 □ Donation 5 □ Other (Specify) All County Cremation Services, 22. Name and Address of Facility Home PA SLACE Function Home PA LOIZOS 3871 DID Columbia DI W EILICOH Cuts 21. Signature of Funeral Service Licensee, 23a. Part1. Finer the di. a , or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Immediate Cause (Final Respire ten Progressive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner (OPD) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Metestate Cener to skull, spine, ribs Completed Celus Cancer autopsy performed' Probable Breast Concer 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

and manner stated.

UD

Relude

MAR 2 1 2008

who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

2 days 5 years 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) MAR IS 2008 Ellicett City MA 21042

G: IS PM

Howard

- American Indian.

White

Education

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

State Registrar 29b. Signature and title of certifier

30. Name and address of person

James

31. Date filed (Month, Day,

4801 Dorsey Hall Dr # 216

29c. License number

D 39638

DHMH 17 Rev 1/2001

			Plea	ase Type or Prin								
			For State	State of Ma	aryland	/ Depa	rtment of	Health and	Mental Hy			09151
	_		Registrar  1. Decedent's Name (First, Middle	la (act)		Cer	tificate of	Deam	2. Date of D	Reg. No	o, C. U U C	3. Time of Death
	Physicia		FVA 1	ROMOFI	_				Month		7, 2008	
	/Medic Examin		4a. Facility Name (If not institution	, , , ,			4b. City, Town,	or Location of Deat			c. County of Dear	
	Examini	ei	Catonsville					Catonsvil			Balti	imore
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. lasi	t birthday)	If Under 1 Yea Months Days	r If Under 24 Hrs	8. Date of Bi	irth	9. Bir	thplace (State or Foreign
	Director			1□ M 2□XF 8	86	Yrs.	Mortano	, riodis wiii.	Jume 7	, 19	21	NY
	and www.t		Usual Residence of Decedent  10a, State 10b, County	/	10c. City, T	own or Loc	cation					10d. Inside City Limits
	Mary -f sho ied a	tor	MD				Baltimo:	re				1 <b>X</b> Yes 2 □ No
	n the	Director	10e. Street and Number		1		10f. Zip Code			10g. C	itizen of What Co	ountry?
	th wit	al D	2117 Denison	n Street				21216			USA	
	r dea er mu	Funeral	11. Maritai Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whit	
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Ş	172 hours after death with the Marylar "natural", or items 23a or 28a-f show adical Examiner must be notified at	ed b		nt's Education	1	16a. Deced	ent's Usual Occi	upation		16b.	Kind of Business	
5	d within 72 hogiene. rr than "natul the Medical	plet	(Specify only highe Elementary/Secondary (0-12)	est grade completed)  College (1-4or 5		(Give I life. E	kind of work done OO NOT use retir	e during most of wo ed)	rking	1		····dau.
717	filed within 72 P 1 Hygiene. other than "nati ent, the Medica	Completed	9	College (1º40) 3	)+)		None	e			None	9
yland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle,					18. Mother's Nar			· ·	
<u> </u>	should I	To	Isadore Rom							nkno		
Mar	12 should be filed v h and Mental Hygie 7 is marked other t traumatic event, th		19a. Informant's Name/Relations Ms. Sharon Corv		1			etand Number or R n St., Ba				Zip Code)
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition	weir (N.II. A			sition (Name of natory or other pl		Date	1	ocation - City or	Town, State
aitimore	Pages nent of int: If its iry or o		1 Daurial 2 □ Cremation 4 □ Donation 5 □ Other (5					tery   3/1	8/08		kesville	
	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service		- F			Cass of Facility HO	·			
ă	Per any		Duad:	HULT MOI	5764	S	ykesvil	le, MD 21	ME & CH. 784	APEL	, PA (BC	OX 195)
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that caused t only one cause on each lir	I the death. I	Do not ente	er the mode of dy	/Ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between
'n	Physician		Immediate Cause (Final disease or condition	a	Res	pin	afory	faclu	ul			Onset and Death
Į	/Medical Examiner		resulting in death)	Due to (or as	a consequen	nce of):	,	Ų			-	. 4
	= Xu	-	Sequentially list conditions,	b Due to (or as	a consequen	nce of):	emo	ma				419.
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<		,.						
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ž Ž	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	eath 3 🗆	Ectopic pregnan	су			23d. Date of de Month	livery Day Year
5	the de	Physician/Medica	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or deat	m 5L	Other (specify)					
7 <u>.</u>	Physician: The law requires that the dithic certificate has been signed by the rail director, page 2 should be detached		Part II. Other significant condition	ons contributing to death b	ut not resultin	ng in the un	derlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to	the cause of death2
	quires	ed by					<del></del>		1 🗆	Yes	2	robably 4 🖃 nknown
ecords	law re as bee 2 sho	Completed							24a. Wa		24b. Were a	utopsy findings available
r	The ate has page	mo;							perl	opsy formed? 2 12 K	death?	completion of cause of 2 ☐ No
VII A	cian: ertific actor,	Be (	25. Was case referred to medica examiner?						ath (Check only	one)		
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	ding I h. After funer	ion:	27. Manner of Death  1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi		y Year)	3b. Time of Injury	28c. Inj W	ury at ork? ∃Yes 2⊟No	28d. Describe	how inj	ury occurred	
VISION	Atten deatl sctor: by the	fical	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of inju	ury - At home	e, farm, stre						ural Route Number,
5	al or	Certification:	4 ☐ Homicide determ	building, etc	c. (Specify)				City or To	own, Sta	te)	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 ☐ Certifyir (Check only one)	ng Physician: To the best of Examiner: On the basis of and manner sta	f examination	edge, death n and/or inv	occurred at the restigation, in my	time, date and plac opinion, death occ	e, and due to the curred at the time	e cause( e, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	Fo the within Forther comple	Mec	29b. Signature and title of certifie	A-,	/	LP	29c. Licer	nse number		29d. D	ate signed (Mont	th, Day, Year)
)				for "	M	0	カ	36947	2	Mo	wich 1	7, 2008 2/228
			30. Name and address of person		eath (Item 23	Ba) (Type, F	Print)	0 2 1	C - 1-	.70	000	21220
				CHIA MD	1009	, h	eduile	10.	aport	u u	(, 10	-, - 8
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 0 20	32. Registra	ai s aunatur	Sport	D					

Certificate of Death

2. Date of Death

3. Time of Death

Eastern Avenue baltimore, MD 21224

Year

Ft Di 1. Decedent's Name (First, Middle, Last)

n il	Patricia, Roth					March	13	4008	4:35	٩M
	4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death		4c. Co	unty of Death		
	Sohns Hopkins Bayui	ew medical Cer	uter	Baltin						
	5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)	Coun	lace (State or Fo try)	reign
-	215.28.3920 Usual Residence of Decedent	75	115.			06.08	.193	2	MD	
- 1-	10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City L	imits
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ŀ	10e. Street and Number	nore bu	TUTINO	10f. Zip Code	<del></del>	1	l0g. Citizer	n of What Coun	itry?	
	220 Homburg Arr			21221			II C	A		
ŀ	338 Homburg Ave	<ol><li>Was Decedent Ever in U.</li></ol>	.S. 13. 1	21221 Was Decedent of F	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No-	U S	Race - Americ		_
	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No				o Rican, etc.)		Black, White,		
	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		S	pecify: Wh	ite	
ľ	15. Decedent's Educ (Specify only highest grade	ation		dent's Usual Occup	ation during most of wor	kina	16b. Kind	of Business/Inc	dustry	
	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	King	D			
L	12		Wait	ress				turant		
	17. Father's Name (First, Middle, Last)					ne (First, Middle,		ırname)		
	William Curran				Marian	Virgi	nia	Trumt	0	
	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or T	own, State, Zip	Code)	
1	Michael Richard	Roth/Son	901	Garland	L Ct. Be	lair,	MD 2			
1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date '	20c. Loca	tion - City or To	own, State	
	4 □ Donation 5 □ Other (Specify)	Ch		ake Cre		15.08		tsvill		
ľ	21. Signature of Funeral Service License	· Holli			ess of FacilitCAF en Past					PA
1	23a. Part1. Enter the disease, or complic	cations that caused the deat					-		Approximate	
-	shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.							Interval Between Onset and Dea	
	disease or condition resulting in death)	Hespirato	ا لم	teri lure					2 hour	<u>:</u>
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	Cause (Disease or injury	- (	/-							
	that initiated events c. resulting in death) Last	Due to (or as a consequence	uence of):							
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	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3	Ectopic pregnanc	у		239	Month	Day Yea	ar
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-	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause give	/en in Part I.	23e. Did to	bacco use	contribute to t	he cause of dea	th?
	while eight durin certainelle coll			,		1 🗆 Y				
		·				24a. Was autop	sy	prior to co	ppsy findings ava mpletion of cau	ailable se of
							rmed? 2 No	death? 1 ☐ Yes	2 No	
ľ	25. Was case referred to medical examiner?					ath <i>(Check only</i> o	ne)			
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						20f Location /6	Street and	11 t	- 1 D - 1 - Al 1 -	_
Ci micalli	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		City or Tou		Number or Hur	al Route Numbe	r,
ilcai cerillicailoii	4 Homicide determined  29a. Certifier (Check only) 2 Medical Examir	building, etc. (Specifician: To the best of my known or: On the basis of examina	owledge, deat	th occurred at the t		City or Ton	vn, State) cause(s) a	nd manner as s	stated.	er,
Medical cer illicalit	4 Homicide determined  29a. Certifier 1 ✓ Certifying Phys	building, etc. (Specif	owledge, deat	th occurred at the to		City or Tow e, and due to the urred at the time,	cause(s) a	nd manner as s	stated. o the cause(s)	er,

Registrar DHMH 17 Rev 1/2001

State

10

Anjail Sharrief

31. Date filed (Month, Day, Year)

e of death (Item 23a) (Type, Print)

M:10. 4940

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? 📗 🗎 🖁 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 18, 2008 **Physician** PEARL 12:23 P M ROSENBLOOM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 □ M 2 K MD 216-03-7249 10/18/1918 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show 1 ☐ Yes 2 X No "natural", or items 23a or 28a-f sh edical Examiner must be notified Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 725 MT. WILSON LANE #639 21208 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: WHITE Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ISADORE** CROOK FANNY WOLINSKY ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ILAYA HOPKINS / GRANDDAUGHTER 4601 NORTH CHELSEA LN, BETHESDA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation FCRBAND CEMETARY 03/19/2008 ROSEDALE, MD 4 ☐ Dorfation 5 ☐ Other (Specify) ure of Fun ral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause [Disease of liquir) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours, after death.

To the Funeral Oirector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 No 1 TYes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a autopsy performed? 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) N (3) PLC 1 Yes 2 No Medical Certification: To 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MN-CH 18 2008

State

31. Date filed (Month, Day, Year)

houses

32. Registrar's Signature

person who completed cause of death (Item 23a), (Type, Print)
Les NO 6701 N Men les T

MAR 2 1 2008



Registrar

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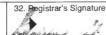
DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 1 2008

MICHAEL L. LEVIN, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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3600

MARCH 19, 2008

				ype or Prin State of Ma					•	_		
			1 = For state Registrar amend #25&2	29a Per MI	G 'G877	3/21	08 III tilicate of	Death	Re	eg. No.2 0 0	8 091	55
	Physicia	an	1. Decedent's Name (First, Middle, Last)		-				2. Date of Death Month March	n 1 <sup>Day</sup> 2008	3. Time of I	
	/Medic		Frank		eo		Rose		March			J AM
	Examin	er	4a. Facility Name (If not institution, give 1089 Generals Hi					nsville		Anne Ar		
	Funeral		5. Social Security Number 6. Sec	x 7. Age	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. I	Birthplace (State or	Foreign
	Director		217-01-2872	]M 2□F	94	Yrs.	Months Days	Tiours IVIII.	July 20	1913 Ma	ryland	
and	)W		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	cation				10d. Inside Cit	y Limits
Mary	-f sho	tor	Marvland Anne Aru	nde1	Cro	owns	ville				1 ☐ Yes	2 <b>X</b> No
ith the	or 28a	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What U.S.	=	
ath w	s 23a nust t	erai	1089 Generals Hig	hway 12. Was Decedent B	Ever in II C	12 1	21032		ocify Vos or No-		merican Indian,	
fter de	r item iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?				ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, W		
DO OUTS a	ral", o Exam	by	3√2 Widowed 4 □ Divorced	1 □Yes 2X\\ If Yes, Give Year or Dates:		1	I∐Yes 2¥∑No	Specify:		Specify:	White	
72 hc	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16	ia. Deced	lent's Usual Occup	ation during most of work d)	ing	16b. Kind of Busine	ss/Industry	
within	than	dwc	Elementary/Secondary (0-12)	College (1-4or 5 NA	i+)		ractor	1)		Construc	tion	
e filed	other	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Name	, ,			
vild be	Menta arked atic ev	To B	Unknown		Ro	se		Unknow	1	U	nknown	
2 sho	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty				-			, City or Town, Stat e, Maryla		
1 and	Healt em 27		Frank Leo Rose Jr.  20a. Method of Disposition	(Son)			Sition (Name of natory or other place		Date	20c. Location - City		
Pages 1	ent of nt: If it ny or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State			natory or other plac art of Ma	, mar	ch 19, 2008	Dundalk,	Maryland	
Dalti.	Department Important: I any injury o once.		21. Signature of Funeral Service Licens	PO I	Sacre				zuua II. nacki Fu	neral Hor	<u>maryranu</u> nes P.A.	
<u>s</u>			/ Mark &	Kume	che	1	005 Dunda	alk Ave.	Baltimor	e, Maryla	nd 21224	
			23a. Part1. Enter the disease, or compl shock, of heart failure. List only o	ications that caused ne cause on each lir	the death. Do	o not ente	er the mode of dyir	. 1		est,	Approximate Interval Bet Onset and D	veen Death
	nysician Medical		Immediate Clause (Final disease or condition resulting in death)	Hrt			erotic	, Hen	rt DI	SCA5	_	
	xaminer			`	a consequenc	e or):						
	+	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e of):						
executed	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (er co	a consequenc	o of:						
	ician a			Due to (or as	a consequenc	e oi).						
The law requires that the death certificate be	igned by the attending physician and be detached for use as the burtal-transit	Physician/Medical		d								
th cert	ending r use	M/ne	23b. was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		nth 3⊡	Ectopic pregnancy	ı		23d. Date of		/
e deal	he att	sicis	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify)		-	Month	Day \	/ear
that th	ed by t detach		Part II. Other significant conditions co	ntributing to death be	ut not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did tot	bacco use contribut	e to the cause of d	eath?
uires i	signe Id be	d by							1 □ Ye	es 2□No 3□	Probably 4	Jnknown
aw requir	s been si	Completed							24a. Was a		autopsy findings	available
The k	ate ha	Jmo:							autops perforr 1∐ Yes			ause of
cian:	ertifica ector, p	Be C	25. Was case referred to medical examiner?				100	26. Place of Deat				
Physi	this c	은	Yes 2 Ho	Hospital: 1 ☐ Inpatie 28a. Date of Inju		Outpatien  o. Time of	t 3 DOA Oth	4 🗆 Nursing Ho		ence 6 Other (S	Specify)	
ding	h. After funer	tion	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	Wor	yat k? Yes 2∐No	20d. Describe no	ow injury occurred		
Atten	ector by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ury - At home, c. <i>(Specify)</i>	farm, stre	eet, factory, office		28f. Location (St City or Town	treet and Number o	r Rural Route Num	ıber,
ial 5	rs afte ral Dir led in	Cert		Dunding, co.	o. (opcony)							
To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		sician: To the best iner: On the basis o and manner sta	of my knowled f examination ated.	lge, death and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	and due to the c red at the time, d	ause(s) and manne date and place, and	r as stated. due to the cause(s	;)
To th	withir To th comp	Me	29b. Signature and title of certifier	2/	Dep	nty	29c. Licens	e number	L 2	29d. Date signed (M	lonth, Day, Year)	
			30. Name and address of person who co	ompleted cause of d	eath (Item 23a	a) (Type,	Print)	0000		2/18	100	
	6		William P.S	Jones,	, mD		695	Ame	rica	21035	5	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 1 200	8 Registr	ar's Signature	Alexander	Will I			ate and place, and pla		
		_		-								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2, Date of Death **Physician** Month 2008 Robert Steinbach March 12:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 750 213th Street Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 10 9. Birthplace (State or Foreign Country) **Funeral** Months Year, 1XM 2□ F 215-30-5851 75 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 2 ☑ No Director Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? n or 21122 USA 750 213th Street ral", or items 23a Examiner must b Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examinea. 1 Tes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Completed by Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator **Plastics** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Steinbach Margaret James ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 750 213th Street, Pasadena, MD 21122 Charlotte Steinbach (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Cemetery 20a. Method of Disposition March 24 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lounsee Stallings Funeral Home, 3111 Mountain Road, Pašadena, MD 21122 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition MOUTH CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown page 2 should Be Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ⚠ No 24a. Was an ISCH EMIC CARDIOMYOPATHY 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Madlin Sten MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1412 N. CRAIN HWY GA GLENBURNIE MO 21061 MARK KIM, MD 32. Registrar's Signature State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:50 <sup>™</sup>PM Garnett Strickland March 4,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Surburban Hospital Bethesda Montgomery 8. Date of Birth 1981 (Month, Day, Year) February 22, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 81 Days Hours 1**⊠** M 2□ F February Director 577-32-8659 Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1∏Yes 2∏No District of Columbia Director Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1457 Girard Street NW 20009 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify ģ 3 XWidowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Self-Employed Twe1th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel L. Strickland Bessie Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Colbert/Sister 6627 Harlan Place NW, Washington DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 12. 1 Burial 2 □ Cremation 3 □ Removal from State Glenwood Cemetery 4 Denation 5 Dother (Specify) 2008 Washington DC 21. Signature o Funeral Service, Linense 22. Name and Address of Facility Frazier's Funeral Home Inc 389 Rhode Island Ave NW, Washington DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPS resulting in death) /Medical Due to (or as a consequence of) Examiner URIWARY Sequentially list conditions, if any, coung to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ □ No 24a. Was an has autopsy certificate 2 **2 N**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Management Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical Funeral Direction to the stelly filled in the

> 10 State Registrar

31. Date filed (Month, Day, Year) MAR 2 1 2008

Truong Bao M.D.

29b. Signature and title of certifier

(Check only one)



and manner stated.

200,190

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DO057124

29d. Date signed (Month, Day, Year)

315100

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,  $\prec$ 

	for State Registrar	State of Ma	-	-	te of De		,	Reg. No.		001 00
ian	1. Decedent's Name (First, Middle, L	•					2. Date of De Month	eath Day	Z U U Ö Year	3. Time of Death
ical	Patricia M. Sta  4a. Facility Name (If not institution, g.			4h City	Town or Lo	cation of Death			2008 County of Death	
ner	Maplewood Park	·		45. Oily		Bethesd.			Montgome	ry
	5. Social Security Number 6. 380-14-2663	Sex 7. Age 1	e (In yrs. last birthd 86 Yrs	Months		Under 24 Hrs. Hours Min.	8. Date of Bio (Month, Date 12/2	rth	9 Right	place (State or Foreign
tor	Usual Residence of Decedent           10a. State         10b. County           MD         Montq	omery	10c. City, Town or Bethes							10d. Inside City Limits 1   Yes 2   No
irec	10e. Street and Number			10f. Zi	p Code			10g. Citi:	zen of What Cou	ntry?
<u></u>	9707 Old George	town Rd.		2	0814-			Un	ited Sta	ites
by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		3. Was Dece If Yes, spe	ecify Cuban, N	anic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	D-	14. Race - Americ Black, White, Specify: Wh.	
Completed	15. Decedent's (Specify only highest g	rade completed)	(G		ial Occupatio ork done durii ise retired)	on ing most of wor	king		nd of Business/In	
E O	Elementary/Secondary (0-12)	College (1-4or 5	4 So	cial W	orker					
To Be C	17. Father's Name (First, Middle, Las Frank Xavier Ma				18		ne (First, Middle Merris		Surname)	
	19a. Informant's Name/Relationship Charles Stanard/			-			nrai Route Numb	-	r Town, State, Zip 05201–	Code)
	20a. Method of Disposition 1 ☐ Burial 2 图 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			crematory or	me of otherplace) Cremate	orv	Date Mar 19 2008		cation - City or To	own, State  Maryland
	21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	MMM &M mplications that caused y one cause on each lin	the death. Do not le.	Rapp 933 ( enter the mo	Gist Av	e. Sil		ng, M	es aryland	20910- Approximate Interval Between Onset and Death
dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to him shart cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a business to (or as a constant)	EUMON a consequence of): A ITON I a consequence of):							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s				2	23d. Date of deliv Month	ery Day Year
þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying	cause given i	n Part I.			ise contribute to t	he cause of death?
Completed							24a. Was auto perf 1∐ Yes		prior to co death?	opsy findings available impletion of cause of 2  No
Be	25. Was case referred to medical examiner?	Hospital:			Other		ath (Check only			
Certification: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	28a. Date of Injur	Year) Inju	e of ry M	28c. Injury at Work? 1 □ Yes		28d. Describe	how injur		
Certific	4 ☐ Homicide determine		iry - At home, farm c. <i>(Specify)</i>	street, facto	ry, office		28f. Location City or To	(Street an wn, State	d Number or Rur	al Route Number,
edical		Physician: To the best of aminer: On the basis of and manner sta	examination and/o							
Mec					c. License nu					

31. Date filed (Month, Day, Year) MAR 2 1 State Registrar

Lause of death (Item 23a) (Type, Print)

N.D. 8218 WISCONSIN AVE #103 BETHESDA

32. Degistrar's Signature

20814 MD

			For State Registrar	State of Marylar		tificate of			Reg. No	e . 200	0 0 1 0 0
	Physicia	an	1. Decedent's Name (First, Middle, La			1		2. Date of De Month	eath Da	y Year	3. Time of Death
	/Medic	al	Educard V 4a. Facility Name (If not institution, gir			4h City Town o	r Location of Death	March	17	2008 c. County of Dea	
	Examin	er	Baltmon Wash		center		Zuivie			nne A	
100	Funeral			Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth V	9. Bji	rthplace (State or Foreign ountry)
	Director		220-22-2857 Usual Residence of Decedent	1½M 2□F 80	Yrs.	Months Days	Hours Min.	01-23-	-1928	8	MD
	yland now at		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				· ·	10d. Inside City Limits
	a-fsl	Director	MD Anne Ar	undel G1	len Bur	nie					1 ☐ Yes 2 🖾 No
	ith the	Jire	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What C	ountry?
1	ath w	rai	121 1st Ave W			2106				U.S.A	
CKEIR 0036	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	1	☐Yes 2XINo	lispanic Origin? (Spe an, Mexican, Puerto Specify:		0-	14. Race - Am Black, Whi Specify: Wh	te, etc.
5-6	72 h "natu	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	ent's Usual Occup kind of work done	eation during most of worki d)	ing	16b. h	Kind of Business	s/Industry
2/2	within sne. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	nications			p,	olt Cit	y Police Dep
4 2	filed Hygi ther		17. Father's Name (First, Middle, Las	t)	Commu	nicacions	18. Mother's Name	e (First, Middle			ly rollice Dep
an		To Be	Edward W. Stocke					Weaver		····,	
4-22 Marylan	2 should by and Ments is marked aumatic evants	Ĕ	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number or Rura			or Town, State,	Zip Code)
	12 m		Mrs. Beverly Sto	cker / wife	121	lst Ave V	V; Glen Bu	ırnie,	MD 2	21061	
EDW altimore,			20a. Method of Disposition	20b. I	Place of Dispos	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City o	r Town, State
ME			1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	_Hemovai from State			cial 03-25	5-2008	E11	kridge,	MD
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee	22	. Name and Addre	ss of Facility Sir	ngleton	Fur	neral &	Cremation
<u> </u>	20 5 2 3		Mark Clark		357					MD 2106	l Services
	Physician /		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	_a Consistre	th. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner			Charma L	Nemed.	Va calina	0_				
		Jer	Sequentially list conditions, if any, feauling to immediate	b. Use to (or as poonsed	μαστικό vil).						
V	tificate be executed g physician and as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· lendov	more	Mu					
90,	e exe sian a urial-		resulting in death) Last	Due to (or as a consec	quence of).	/					
68760,	cate b	edical		▲d							
	ding p	/Me	IF FEMALE:	23c. If yes, outcome pf pregn	ancv					004 D-1(-4	
). Box	e death cert he attending ed for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3□	Ectopic pregnanc Other (specify)	<i>y</i>		ĺ	23d. Date of de Month	Day Year
P.0	d by t letach	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to death but not res	sulting in the un	iderlying cause giv	en in Part I	23e Did	tobacco	use contribute	to the cause of death?
Division or Vital Records,	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by	Mind Fanil	afron.						2  No 3  F	
o o	has be	plet	l l	•				24a. Was		24b. Were a	autopsy findings available completion of cause of
<u> </u>	The ate h	Mo						perf 1∐ Yes	ormed? 2 <b>X</b> IN	death?	s 2□No
/ita	cian: ertific	Be (	25. Was case referred to medical examiner?				26. Place of Death	h (Check only	-		
or	Physician: The krithis certificate harral director, page 2	은	1 Yes 2 No	Hospital: 12 Inpatient 2	T		4 Li Nui sirig Ho			6 □Other (Sp	ecify)
n o	ding P	ion:	27. Manner of Death  1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Woi M 1 □	yat k? Yes 2 □ No	28d. Describe	now inji	ury occurred	
18:0	death ctor: y the	icat	3 Suicide 6 Could not b	De Place of injuny. At h	ome, farm, stre			28f. Location	(Street a	and Number or F	Rural Route Number,
<u>5</u>	al or / s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. <i>(Speci</i>	fy)		ļ	City or To	own, Sta	te)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying P (Check only one) Medical Exa	hysician: To the best of my knominer: On the basis of examinate and manner stated.	owledge, death ation and/or inv	vestigation, in my	opinion, death occur	and due to the red at the time	e cause( e, date a	s) and manner and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. D	ate signed (Mor	nth, Day, Year)
			Bata	am		D4	3977		11/0	rele	14 2008.
	10		30. Name and address of person who	completed cause of death (Itel	m 23a) (Typo, I	2) alen	Burne	. M	<b>D</b> .	21061.	
	Sta		31. Date filed (Month, Day, Year)	2. Registrar sign	ature	of the same					
	Registr	वा	MAR Z I ZU	De la	S. S						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Spellman 8:40 PM Thomasine 03 2008 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore UMMS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11 | 28 | 19 4 6 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2 F 218-44-948 Director 61 MD Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits N/A 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Apt 327 501 E. Preston 21202 SA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itel ury or other traumatic event, the Medical Examines 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 2 3 ☐ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry N/A (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Davis Emma Young 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hakim Ali - Brother Randallstown, MD 21133 3908 Amy Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or King Memorial Pk 3-20-2008 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East la Warren 1101 E. North Avenue Balto, ΜĎ 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic **Physician** Shack 1 week disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner 3 weeks Pheumonia Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the aid 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed ascinomo 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

8

Registrar
DHMH 17 Rev 1/2001

State

Colleen

31. Date filed (Month, Day, Year) MAR 2 1 2 NPI: 1821206673

B-more, MD

MD

Greene

5.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cibson

2008

232

08-02004 Marie Louise Sasse Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lease Type of Fills in black indenble link. Lisure All Copies Are Legisler	
State of Maryland / Department of Health and Mental Hygiene	2
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	F	1- For State Certificate Of Death Reg. No.														
Physicia dical Examin	ın/	1. Decedent's Nam Marie Lo		Δ.								2. Date of Death  Month Day Yes March 13, 2008			3. Time of Death 1510 hrs	
culcal Examin		4a. Facility Name (				umber)		4	o. City, Tov	vn, or Lo	ocation of		TVICE CIT I		ounty of Dea	ith
		Harbor Hos							Baltimo	re						
Funeral	-	5. Social Security I	Number	6. Sex		7. Age	(In yrs. last b	oirthday)	If Under	1 Year	If Under	24Hrs.	8. Date of E	Birth(MM/DD	/YYYY) 9. E	Birthplace (State or
Director					M 2 XF		43	Yrs.	Months	Days	Hours	Min.	10/9/	1964	Fore	Country) MD
	L	208-48-11		<u> </u>	VI Z AF		40	113.					10/ 5/	1704		
ŕ	ŀ	10a. State	10b. County			11	I0c. City, Tov	wn or Location	on						10d. Inside City Limits	
& & J		MD	Anne	Arun	dol		Lint	hicum								1 Yes 2 X No
Maryland 28a-f show any <u>d at once.</u>	흵	10e. Street and Nu		TI GII	- C				10f. Zip C	ode	_			10g. Citizer	of What Co	ountry?
e Mar	인	402 Beec		Dood	ı				21	090				II	S.A.	
ith th		11. Marital Status	liwood	Ruau	12. Was De	cedent F	ver in U.S.	13. Was			anic Origi	in? (Spe	cify Yes or I			erican Indian, Black,
ath w	Funeral		ied 2 X	Married	Armed F	orces?		If Ye	es, specify	Cuban,	Mexican,	Puerto R	tican, etc.)		White, etc.	
ter de		3 Widowed	4 Di	vorced	1 X Yes If Yes, Give Ye	2 <u> </u> ear	No	1	Yes 2 X	No	specify:			Sp	ec <i>ify</i> : wł	nite
ars af	b b		15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b.											16b. Kin	d of Busines	s/Industry
215-0036 nal Hygiene. red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	Elementary/Sec	during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4 or 5+)													
D36	ם		31												Administration	
5-0 ed wi fygie other		7. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden											ımame)			
21 be fill riked rent,	ալ	Rodney Walter Plank  Judith A  19a Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural R												an Taura Ca	ata Zin Codo)	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	٩	19a. Informant's N														
p, MD 21 and 2 should lealth and Me tem 27 is ma	ļ	Mr. Mark		/ h	usban	d	Joh Dia	402 ce of Dispos				ad;	Linthi Date	cum,		or Town, State
Fe, s l ar of Hez		20a. Method of Di	Sposition  X Crematic	op 3	Removal	from Sta	te cre	matory or oth	ner place)							
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene. In the Maryland Hygiene, and the filed With a Maryland is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		/ _	5 Other	/			Ches	sapeak					0/2008			ville, MD
Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Sign ture of Funeral & Company Consee MOO30 22. Name and Address of Facility Singleton Funeral & Company Consee 1 2nd Ave SW; Glen Burnie, MD 21061														
<b>Ⅲ</b> %Ω≌.5		28a Pyrt I. Enter	KIN	2	11	10/0	the death D									Services Approximate Interval
Physician /Medical		failure. List o	the disease, only one caus	e on ea	ch line.					dynig,	30011 03 0	araido or	,000,000		,	Between Onset and Death
xaminer		Immediate Cause or condition resul			Probab  Oue to (or as		rdiac a	irrhythn	na							
		or condition resul	ung in death,	, L	Jue to (or as	a conse	equence on.									
	er	Sequentially list of if any, leading to	immediate		Due to (or as	a conse	equence of):									
	min	cause. Enter Und (Disease or injury	that initiated	C	Due to (or as											
cuted ind transit	Examiner	events resulting i	n death) Las	d.	Due to (or as	a conse	equence or).									
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760, icate be ex physician the burial	n/Medical	IF FEMALE:					ne of pregna		21/06	11_				23d.	Date of deli	very
68760, certificate be nding physic	N/I	23b. Was deceder past 12 mont	-	the	1 Live	e birth		2 F	etal death	3	Ectopi	c pregna	ncy	N	<b>Month</b>	Day Year
x 6 th cer trendi	sicia	1 Yes 2		Inknown	1 '=	_	time of deat	b 5 0	ther (Spec	ify) _						
that the death certifith that the death certifith red by the attending detached for use as the control of the c	Phys	Part II. Other sig			9	known	h hut not ross	ulting in the	underlying	cause c	iven in P	art I	23e. D	id tobacco u	se contribute	e to the cause of death?
P.O.	by F	Part II. Other sig	nificant con	litions	contributing	j to deat	ii but not res	uiting in the	underlying	<b>00050</b> 9	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					Probably 4 Unknown
S, P.C puires that an signed Id be deta	ed												24a. W	/as an	1 24b. Wer	e autopsy findings available
ords, w requir as been s	per													utopsy erformed?	prior deat	to completion of cause of h?
Che la	Completed													es 2 No	1 🗸	Yes 2 No
Vital Rec ysician: The l his certificate l director, page	Bec	25. Was case ref	erred to medi						2		of Death					
Vit hysici this c	To E	examiner?	2 No	1	Hospital: 1			R/Outpatien			Other <sub>4</sub>		g Home 5			Other:
n of ing Pt After funera		27. Manner of De			28a. Da (Mo	ate of Inju	ury (ear) 2	28b. Time of	Injury 12		ry at Worl	_ 1	28d, Desci	ibe how injui	y occurred	
ion ttend death.	atic	2 Accident		ending vestigati	on								OR Locati	an /Stroot or	ad Number o	or Rural Route Number, City
Division of Vital Records, tot or Attending Physician: The law require star death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the control of the funeral director, page 2 should the control of the funeral director.	Certification:	3 Suicide		ould not	be		njury - At hon	ne, farm, stre	et, factory	, office t	oullaing, e	etc.		n, State)	ig Number C	Rulai Route Number, Oity
Spital nours neral filled	Se	4 Homicide	·	etermine	11 (0,000								I due to the	20120(2) 222	d manner as	stated
Division of N To the Hospital or Attending Phy whithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	g	(Check only one)	Certifying  Medical E	Physic xamine	ian: To the t r:On the bas	best of ma is of exa	ny knowledge imination and	e, death occu d/or investiga	irred at the ation, in my	opinior	ate and pi n, death o	ccurred a	at the time,	date and plac	ce, and due	to the cause(s)
To t To t	Medical	29b. Signature a			and manne	er stated.					se number					(Month, Day, Year)
	=	1 Constitution	14.4	1	Inil	- IMI	D			O.C.	M.E.			Marc	ch 15, 20	08
		30. Name and ad	Ideas of nor	on who	completed c	,	_	(3a)								
		Donna M.					cal Exami		1 Penn	Street	, Baltim	ore, M	ID 21201			
					32	Registra	ar's Signatur		. 10							
9	tate					Select		AT-AA	442. //							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

08-020	90
Brvant	Sterling

ryant Sterling	State of Maryland / Department of Health and Mental Hygiene  - For State  - Certificate of Death  Reg. No. 2 1 1 8 1 9 1											
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		Month Day Year	3. Time of Death 0125 hrs								
ledical Examiner	Bryant Ster  4a. Facility Name (if not institution, give street and number)	ling 4b. City, Town, or Location of Death	March 15, 2008 4c. County of Death									
	944 Bennet Place	Baltimore										
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 217-80-9545 1X M 2 F 42	y) If Under 1 Year If Under 24Hrs  Months Days Hours Min	Foreign	hplace (State or n untry) MD								
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits								
	MD N/A Balti	more		1 X Yes 2 No								
Maryland 28a-f show datonce. rector	10e. Street and Number	10f, Zip Code	10g. Citizen of What Coun	ntry?								
th the Maryland 23a or 28a-f sho notified at once.	944 Bennett Place	21223 B. Was Decedent of Hispanic Origin? ( S	USA pecify Yes or No- 14, Race - Americ	can Indian Black								
r death with or items 23 must be no Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Prican, etc.) White, etc.	our maian, basin,								
safter de ral", or niner mi	3 Widowed 4 Divorced or Dates:	Yes 2 X No specify:	Specify: Bla									
Salate our	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	cedent's Usual Occupation (Give kind of ing most of working life. DO NOT use ret	work done ired) 16b. Kind of Business/I Davenport									
5-0036 by continuous properties of the contin	Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade N/A In	tallation Labor	er Davemport	Proofin								
21215-0036 ould be filed within 72 h d Mental Hygiene. s marked other than "n ic event, the Medical E. To Be Complete			e (First, Middle, Maiden Surname)									
121 Id be fil Aental Inarked event,		Inez L	Rural Route Number, City or Town, State	, Zip Code)								
O = 5 = 5			Balto, MD 212 Date 20c. Location - City or									
re, MC s 1 and 2 s of Health an If item 27	A V D day of Company of from State Crematory	or other place)	i									
E 9 9 5 7	4 Donation 5 Other Specify:	t Memorial PK 3		, MD								
Baltim permit. Pag Department Important: injury or o	21. Signature of Fune al Service Licensee	22. Name and Address of Facility  March Funcial Ha	1101 E. North Are	n a								
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not e	inter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and								
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Heroin and Alcoho	1 Intoxication		Death								
,,,diffici	or condition resulting in death)  Due to (or as a consequence of):											
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
ted nisit Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
0,  e be executed  rsician and  burial - transit	d											
50, te be execut ysician and burial - tra	AMENDED 23a, pt.II,  IF FEMALE: 23c. If yes, outcome of pregnancy	27, 28a-f per me	g877 3-24-08 vt 23d. Date of deliver	ry								
5876 ertificat fing ph	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr		Day Year								
). Box 6876( the death certificate by the attending physiched for use as the beautiful physician/Me	4 Pregnant at time of death 5 I Yes 2 No 9 Unknown g Unknown	Other (Specify)										
O. Bat the dath the tracked			23e. Did tobacco use contribute to									
S, P.O. uires that the n signed by d be detach	Hypertensive Cardiovascular Dis	ease	1 Yes 2 No 3 Pro	utopsy findings available								
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tal Rec		26.Place of Death (Chec	1 Yes 2 No 1 Y	es 2 No								
Vital hysician hysician this certial director		Other	sing Home 5 Residence 6 Other	er: Scene								
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ivision or Attendi after death. Director:	Natural 5 Pending 3-15-08 1:1	7 Yes 2 X No n, street, factory, office building, etc.	28f. Location (Street and Number or R	Rural Route Number, City								
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach contification: To Be Completed by D	3 Suicide 6 Could not be determined (Specify) residence		or Town, State)  944 Bennet Pl. Ba	lto. City. M								
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after defined to the standard physician. To the Funeral Director: After this certificate has been signed by the attending physician to the funeral director, page 2 should be detached for use as the beautification: To Bo Completed by Physician Management of the physician o		occurred at the time, date and place, a	nd due to the cause(s) and manner as sta	ated.								
To To Con.	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (M	lonth, Day, Year)								
	hy w, m, D	O.C.M.E.	March 15, 2008									
	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201										
Stat	g 31. Date filed (Month, Day, Year) 32. egistrar's Signature	Carot, Balantoro, MD 21201										
Registra	MAR 2 0 2008   Mary 1	grava.										
DHMH 17 Rev 1/200	ORI	GINAL	OCME									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18 **Physician** 2008 ear MARCH 10:50 A M oure /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTON GARDENS OF PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/04/1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M M 2 □ F **Funeral** Hours Months Days M<sub>0</sub> 486-05-5531 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 1840 REISTERSTOWN ROAD, #152 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WW I I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify. Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** SOCIAL SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SWARTZ **ESTHER** GROSSMAN SAMUEL ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ERIC SWARTZ 3206 FERNDALE ST., KENSINGTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State 03/20/2008 ANSHE NEISEN CONG. ROSEDALE, MD 5 ☐ Other (Specify) 4 Domation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 at caused the death. Do not enter the mode of dying, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other Division or Vital Records, \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of 28a. Date of Injury 27. Manney of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide or A To the Hospital within 24 hours at To the Funeral E 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and titl 29d, Date signed (Month, Day, Year)

State Registrar person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**Physician** /Medical Examiner The law requires that the death certificate be executed and

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

r 28a-f show notified at

ral", or items 23a or Examiner must be r

"natural",

if Health and Mental Hygiene.
item 27 Is marked other than "natul other traumatic event, the Medical

permit. Pages 1 Department of H Important: If ite any injury or ot

burial-transi use as the for detached page 2 certificate funeral director, After this

Physician: or Attending 24 hours after death, Funeral Director: / filled in by the

Division or Vital Records, P.O. Box 68760,

Hospital completely within 24

State Registrar

29b. Signature and title of certifier 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) M. COOPER

MAR 2 1

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

6503 mo 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

HEIGHTS AVE

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

n 3037

28f. Location (Street and Number or Rural Route Number, City or Town, State)

M ARUH

29d. Date signed (Month, Day, Year)

BACT. MD 21215

18,2008

DHMH 17 Rev 1/2001

		For	Plea	ase Type or F State of			ndelible Ink partment of F					_egible.		
		1 - State Registrar				C	ertificate of	Death	1		Reg. No.	2008	3 0916	5
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/Medi		IRV					STAPF			MARC	H 10	6 2008		M
Examir	ner	STERLING	G ASSIS	on, give street and num STED LIVIN(	,			IMORE			4c. (	County of Dea		
Funeral Director		5. Social Security N 212-05-		6. Sex 1 X M 2 ☐ F	7. Age ( <i>In yr</i> . <b>91</b>	s. <i>last birthd</i> a Yrs.	y) If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, D 02/07	rth ay, Yea <i>r)</i> 1/1917	9. Bi	rthplace (State or Fore ountry) PA	ign
pu »		Usual Residence of	Decedent 10b. County	,	100.0	City, Town or	ocation						10d. Inside City Limi	ite
/aryla f shov ed at	ō	MD	ĺ	ALTIMORE	100.	HALET							1 □ Yes 2 🛣 N	
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ems.	Funeral	11. Marital Status		12. Was Dece	dent Ever in ces?	U.S. 13	B. Was Decedent of H	lispanic O	rigin? (Sp	ecify Yes or No Rican, etc.)	0- 1	14. Race - Am Black, Whi		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notifiled at	by	1 ☑ Never Marr 3 ☐ Widowed		ried 1 ☐ Yes	2 XNo		1 □ Yes 2 💢 No			, many every			HITE	
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s 1 and 2 should f Health and Mer item 27 is marke other traumatic				/ BROTHER	206		10 LORENA position (Name of	AVEN		HALETH Date			21227	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	Cremation	3 □Removal from S	State	cemetery, c	rematory or other pla	· i		9/2008		cation - City o		
rmit. partm porta y inju		21. Signature of Fu	ineral Service	Licensee			22. Name and Addre		Ha.	<del>-</del>			S., INC.	
8 8 2 6 8		you	Clan	2-					TOWN	ROAD -	. PIK		MD 21208	}
				complications that ca only one cause on ea	used the de ach line.	eath. Do not e	nter the mode of dyli	ng, such a	s cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
Physician /Medical		immediate Cause disease or conditio resulting in death)	(Final n	_a	1110	71 on	fremon	ne					Inntl	
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or Atter ter dea irector	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	nined Zoe. Place	of injury - At ig, etc. (Spe	home, farm, s	street, factory, office				(Street and own, State)		Rural Route Number,	
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To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	Medical	29a. Certifier (Check only one)	2  Medica	ng Physician: To the I Examiner: On the ba and mann	sis of exami	ination and/or	investigation, in my	opinion, de	eath occur	rred at the time	date and	place, and du	is stated. le to the cause(s)	
To th withir To th comp	Me	29b. Signature and	title of certific	er			29c. Licens	se number			29d. Date	e signed (Mor	oth, Day, Year)	
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5		30. Name and add	ress of perso	who completed cause	e of death (It	em 23a) (Typ	e, Print)		0.0	14 ~	0 -	(2) -		
/		31. Date filed (Mon	oth, Day, Year	AV620117)	edistrar's Sig	inature 25	th AUP	are	184	4/ /!	ソマ	1209	· · · · · · · · · · · · · · · · · · ·	
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			For State Registrar	State of	Marylan	-	artment of I rtificate of			-	giene Reg. No. 2	008	09166
	Physic /Medi		1. Decedent's Name (First, Middle Gayle Miche)							2. Date of De Month March	ath Day	Year 2008	3. Time of Death 11:45
	Examir		4a. Facility Name (If not instituti Stella Maris	Ноѕрісе			4b. City, Town, o	n	of Death		4c. Col Bal	unty of Death timore	
	Funeral Director		5. Social Security Number  213-54-4477  Usual Residence of Decedent	6. Sex 7 1 □ M 2	. Age (In yrs. I 58	last birthday) Yrs.	) If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min			8. Date of Bir (Month, Da 08-27-	th ly, Year) 1949	9. Birth Cou Mary	place (State or Foreign ntry) Tand
	death with the Maryland ms 23a or 28a-f show	ector	10a. State         10b. Count           MD         Balts			y, Town or Lo sedale	·						10d. Inside City Limits 1 ☐Yes 2000000000000000000000000000000000000
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventiner must be motified at once.	Completed by Funeral Director	10e. Street and Number  1206 64th Stree	12. Was Decede		S. 13. V	10f. Zip Code 21237 Was Decedent of If Yes, specify Cub	Hispanic Or	rigin? (Spec		United	of What Cou	S
9800	ours after our iter	d by Fur	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		√ No		1⊡Yes 2 <del>/⊡</del> /No	Specify		Rican, etc.)	1	Black, White, ec <i>ify: Whi</i> t	
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	1 and 2 sho Health and em 27 is m ther traum		19a. Informant's Name/Relation  Roland B. Staud  20a. Method of Disposition		20h P	1206	ng Address (Street 64th St	reet .		ale MD	. 2123		
Baltimore,	nit. Pages artment of ortant: If its injury or o		1 ☐ Burial 2 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (-	Specify)		Itop S	sition (Name of natory or other plate of control of con	orp.	03-19	-2008	Towson	, Mary	
B	permi Depa Impo any ir		23a Part 1. Enter the disease, o shock, or heart failure. Lis	complications that cau	ised the death	I	nc. 7922	Wise	Aven	ue Dun	dalk M		
9	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. LUNG	CANCER as a consequ	ience of);							Onset and Death
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3,0928	ficate be executed physician and s the burial-transit	dical	resulting in death) Last	c	as a consequ	rence of):							
O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		th 2☐ Fetal nt at time of de	death 3	] Ectopic pregnand ] Other <i>(specify)</i> _	БУ			23d.	Date of deliv Month	ery Day Year
Records, P.	w requires that s been signed t should be deta		Part II. Other significant condit	ions contributing to deat	th but not resu	ilting in the ur	nderlying cause gi	en in Part I	l. 		obacco use d ′es 2 □ N		he cause of death?
	sician: The law r certificate has be irector, page 2 sh	Completed by	25. Was case referred to medical							1 □Yes	rmed? 2 <b>X</b> No	4b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
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Division o	Attending Ph ir death. ector: After th by the funeral	Certification: T	27. Manner of Death  1 \( \) Natural 2 \( \) Accident 3 \( \) Suicide 4 \( \) Homicide	not be 28e. Place of	Injury - At họi	28b. Time of Injury	Wor	ryat k? ]Yes 2 □	No 26	3d. Describe h	now injury oce	curred	al Route Number,
Ö	Hospital or 4 hours afte Funeral Dir tely filled in	Medical Cert	29a. Certifier 1 Certifyi	ng Physician: To the be i Examiner: On the bas	is of examinat	wledge, death	n occurred at the t	ime, date a	nd place, a	City or Town	cause(s) and	d manner as s	stated. o the cause(s)
	To the within 2 To the comple	Med	29b. Signature and tipe of certific	and manner	r stated.		290 licens	e number	21		29d. Date sig	gned (Month,	Day, Year)
	5		30. Name and address of person  DR. TARIQ MAH		· ·	, , , , ,	Print)	TIMO	NIUM.	MD 210	)93		
	Sta Registr		31. Date filed (Month, Day, Year, MAR 2 1	1	istrar's Signat								

MARCH 16, 2008 11:45 a.m.

GAYLE STAUBS

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Lucille Edith Struckman **Physician** March 18, 2:00 P M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** College Manor Assisted Living Lutherville Baltimore Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. 22,1919 Director 88 Maryland 220-09-5553 Dec. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Directo Maryland Dundalk Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7009 Dunmanway 21222 Apt. B United States Funeral Pages 1 and 2 should be filed within 72 hours after death items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 □ Divorced White 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell A. Wolfe Emma L. Boon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11131 East Harvard Dr. Aurora, CO 80014 Mr. Russell W. Struckman (Son) Department of Health Important: If item 27 any injury or other treatment. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 3/22/2008 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 3216 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE Physician ALZHEIMER'S /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. It is underly cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Vear 4☐Pregnant at time of death 5 Other (specify) a linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Director: within 24 hours after

To the Funeral Dire

completely tilled in b

6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

016619

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

www. MD

300 W. SEMINARY C.VERGARA-SOARES

AVE. LUTHERVICLE, MD. 21093

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 2 1 2008

29b. Signature and title of certiffer



Physician /Medical

Examiner

Director

Be Completed by Funeral

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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at appear.

Physician /Medical Examiner

Registrar		Certif	ficate of Death	Mental Hygi	g. No. 🤈 🧻 🦳	00166
Decedent's Name (First, Middle, Last)	)			2. Date of Death	6 U U (	3. Time of Death
Catherine Chisho	lm Sarandria			March	19 2008	6:33 AM
Facility Name (If not institution, give s			o. City, Town, or Location of Dea	th	4c. County of De	
Stella Maris Hosp Social Security Number 6. Sex			Timonium Under 1 Year   If Under 24 Hrs	8. Date of Birth	Baltimo	rthplace (State or Foreign
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ual Residence of Decedent  State 10b. County	140.00	/. Town or Location		JOE 10 13	03 MI2	
D Baltimore		monium	on			10d. Inside City Limits 1 □Yes 2√ No
. Street and Number		1	0f. Zip Code	10	g. Citizen of What C	ountry?
2300 Dulaney Vall			21093		USA	
Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces?	3. 13. Was	Decedent of Hispanic Origin? ( s, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
3 X Widowed 4 □ Divorced	1 ∐Yes 2 ⊠No If Yes, Give Year or Dates:	1 🗆	Yes 2 No Specify:		Specify: Wh	ite
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lementary/Secondary (0-12)	College (1-4or 5+)	life. DO I	n of work done during most of wo NOT use retired) Iome Maker	nuty	Own Hom	ne.
Father's Name (First, Middle, Last)			T	me (First, Middle, Ma		ie
oseph C. Chisholm	1			y Magdalen	,	
a. Informant's Name/Relationship (Typ	pe. Print)	19b. Mailing A	ddress (Street and Number or R			Zip Code)
ary Webb/Daughter			Cross Street,			
Method of Disposition     Mathod of Disposition     Mathod	lemoval from State Saci		t Catholic 03-	Date 20 24-08	oc. Location - City o	r Town, State Ster, VA
Signature of Funeral Service License	ie Cam		ame and Address of Facility RI SO York Rd To	uck Towsor	Funeral	Home, Inc.
a. Part 1. Enter the disease, or compile shock, or heart failure. List only on	cations that caused the death.				EIZU4	Approximate Interval Between
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at initiated events C.						
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trimitated events culting in death) Last d.  D. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ▼ No 9 □ Unknown  It II. Other significant conditions continued to the past 12 months?	Due to (or as a consequent).  3c. If yes, outcome of pregnant at time of de 9 Unknown  ospital: 1 Inpatient 2 E	ence of):  ncy death 3   Ect eath 5   Oth  ting in the underl  ER/Outpatient 3  28b. Time of Injury	lying cause given in Part I.  26. Place of De	1 🗆 Yes  24a. Was an autopsy performe 1 🗀 Yes 2	Month  2 No 3 F  24b. Were a prior to death?  1 No 1 Ye  Ccc 6 Nother (Specific Accessed)	Day Year  o the cause of death?  Probably 4  Unknown  utopsy findings available completion of cause of s 2  No

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State <sup>31.</sup> Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

108

DR. TARIQ MAHMOOD 23

31. Date filed (Month, Day, Year)

MAR 2 1 2008

2300 DULANEY VALLEY RD.
38. Registrar's Signature

08-02076	
Helen Thomas	

Hele	n Thomas		- For State	State o	of Maryland /		ment of ficate of		d Menta		teg. No.	20	08 0916
	Physicia	n/	egistrar I. Decedent's Name	(First, Middle,Last)						2. Date of Dea Month	Day	Year	3. Time of Death 0000 hrs
Mer	<sup>e</sup> ≏al Examir	er -	Helen Ha. Facility Name (if	Thomas			1	b. City, Town, or	Location of	March 14		County of Deat	
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	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (										
	212 uld be Menta mark	라	Forbes 19a. Informant's Na	me/Relationship (Ty	pe, Print )		19b. Mailing	Address (Stree	et and Numb	Der or Rural Route N	umber, C	City or Town, Sta	te, Zip Code)
	MD and 2 short alth and an 27 is aumatin		Matthew	Thomas	/Son					Dr. So	outh	n Dator	32119 na. FL
	e, le, land Healt Fitem		20a. Method of Disp	osition	Removal from Sta		ace of Dispos ematory or oth	ition (Name of ce ner place)	metery,	Date	20c.	. Location - City o	or Town, State
	Pages ent of nrt: Il	Н	4 Donation 5	Other Specify:		Che	-	ke Cre	m.	03.17.08	ВВ	eltsvil	lle, MD
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other thingury or other traumatic event, the Med	1	21. Signature of Fur	neral Service Licens	ee MOIHY	3	22. N	lame and Addres	s of Facility	CAFA/St	ephe	en D. I	Lohrmann,
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	quires en sign			<del></del>						24a. W	as an		autopsy findings available
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	of Vi ing Physi After this uneral dir	욘	1 ✓ Yes 27. Manner of Deat	2 140	28a. Date of Inj	ury	28b. Time of	Injury 28c. Inj	jury at Work		oe how i	njury occurred	
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	Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attern completely filled in by the funeral director, page 2 should be detached for ur		29a. Certifier (Check only one)	Certifying Physici Medical Examiner	an: To the best of n	ny knowledg amination an	e, death occu id/or investiga	rred at the time, ation, in my opinio	date and pla on, death oc	ace, and due to the courred at the time, do	ause(s) ate and p	and manner as s place, and due to	stated. the cause(s)
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P	2010		30. Name and addr	ress of person who	completed cause of	death (Item	23a)	- ا					
0	ponel.			nica-Pollak Mi				111 Penn S	Street, Ba	altimore, MD 21	201		
	S Regis	tate	31. Date filed (Mon		32 Registr	ar's Signatu	re	d's					
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DHMH 17 Rev 1/2001 OCME 2006

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Tanice Thompson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02131 State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 16, 2008 1037 hrs Medical Examiner Thompson Janice 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 1 Commerce Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Min. Months Davs Hours 04.09.1930 Director 77 unk 1 M 2 > F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 Yes 2 No tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. MD unk unk 10g, Citizen of What Country 10f, Zip Code 10e. Street and Number U.S.A. unk ö unk 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Mantal Status White, etc. Armed Forces' 1 Never Married 2 Married Description of the should be filed within 72 hours after dean Vepartment of Health and Mental Hygiene.

uportant: If item 27 is marked outury or other traum. Yes Specify:White Yes 2 No specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Home Maker <u>Own Home</u> 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Hoffman Herman Wehr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thompson/Son 64 Ewing Dr. Reisterstown, MD Mark B. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State 03.21.08 Beltsville, MD Chesapeake Crem. Donation 5 Other Specify: 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21 Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto.. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to or as a consequence of): Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27 per ME g877 3/28/08 amh X UNPENDED attending physician for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy I ive birth Fetal death past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has b death? performed? ✓ Yes 2 **V** 2 No this certificate the Hospital or Attending Physician: hin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 ✓ Other: Scene ER/Outpatient 3 DOA Inpatient 2 1 🗸 Yes မှ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1XX Natural 1 Yes 2 No 5 Pending To the Funeral Director: Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2 State

DHMH 17 Rev 1/2001 OCME 2006

Registra

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

I BELLEVEL

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Pamela E. Southall, MD 31. Date filed (Month) Pay Year

DUIVIE

March 17, 2008

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Year 2008 Anthony H. Uttenreither Narch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 0 Sedale BaltiMor Saruahe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Number s. last birthday, 60yr Months Days 1 M 2 □ F 218-48-2285 Director 2-12-1948 Md. Usual Residence of Decedent after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2√E No Directo Md. Harford BelAir 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Summershade Ct. 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White ō 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility Worker Balto.Gas/Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be пента мента Charles Uttenreither Margaret Simpson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Jeffrey Uttenreither 401 Summershade Ct. permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery crematory or other place)
Bayview 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-21-2008 Baltimore 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility teccell. Schimunek Funeral 9705 Belair Road 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earh line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lonar /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed rrhosis attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death signed by the a 5 Other (specify) 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by nagea 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical

Division or Vital Records, P.O. Box 68760

ours after death neral Director: filled in by the t within 24 hours a

To the Funeral I

completely filled

29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 064408 Gan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Behavi 9000 Franklin Square Drive Baltimore . ATau 31. Date filed (Month, Day,

and manner stated

State Registrar

	for State Registrar	State of Marylan	Certifica	te of Death	Re	g. No.	0217
siciar	Decedent's Name (First, Mid	dle, Last)			Date of Death     Month	n Day Year	3. Time of Death
edica	Frank E. Uhlh					17, 2008	2:42 A
minei			4b. City	, Town, or Location of Dea	ith	4c. County of Dear	th
	47 S, Carrollt 5. Social Security Number	on Ave . 6. Sex 7. Age (In yrs. I		altimore er 1 Year   If Under 24 Hr	s   0 D-1 - ( B' )	n/a	
al or	216-07-7268	1 M 2 □ F	Months		. (Month, Day,	Year) Co	thplace (State or Forei ountry)
	Usual Residence of Decedent	9	1		5/3/16	Mar	yland
	10a. State 10b. Coun	ty 10c. City	y, Town or Location				10d. Inside City Limit
\$	MD	n/a	Baltimor				1 XYes 2 □ N
Funeral Director	10e. Street and Number	шта		p Code	10	ng. Citizen of What Co	ountry?
2	47 S. Carroll	ton Ave		21223			,
STOC	11. Maritaf Status	12. Was Decedent Ever in U.		edent of Hispanic Origin? (	Specify Yes or No-	USA 14. Race - Ame	nican fndian.
		Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, spe	ecity Cuban, Mexican, Pue	rto Rican, etc.)	Black, White	
AP		ed Year or Dates:	1 □ Yes	2 № No Specify:		Specify:	White
Completed	15. Decede	ent's Education lest grade completed)	16a. Decedent's Usi	ual Occupation ork done during most of we use retired)	orking 1	6b. Kind of Business/	
icu	Elementary/Secondary (0-12)		life. DO NOT	use retired)	// King		
Loc.	5		Firefi	ghter		Baltimore	City
Be	17. Father's Name (First, Middle	a, Last)		18. Mother's Na	me (First, Middle, M	laiden Sumame)	
P	Frank E. Uhlh	orn, Sr.		Margar	et Arnold		
	19a. Informant's Name/Relation	nship (Type, Print)	19b. Mailing Addres	s (Street and Number or F	ural Route Number,	City or Town, State, 2	Zip Code)
	Mrs. Jean Deam	er / Daughter	5209 Risi	ng Sun Lane	Ellicot	t City, Md	21043
	20a. Method of Disposition	20b. PI	lace of Disposition (Na emetery, crematory or	me of		Oc. Location - City or	
	1,MaBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		don Park C		21/08	Baltimore,	Marvland
	21. Signature of Funeral Service			nd Address of Facility Lo			•
	Lugare	VIII	70	Wilkens Ave.			
	23a. Part1. Enter the disease,	or complications that caused the death					Approximate
	Immediate Cause (Final	st Phy one cause on each line.				- 13	Interval Between Onset and Death
ı	disease or condition resulting in death)	a. RENAL FAI					MONTHS
		Due to (or as a consequ	,				
er	Sequentially fist conditions, if any, leading to immediate	b. Due to for as a consequ					MONATS
Examin	cause. Enter Underlying Cause (Disease or injury	<b>\</b>					
Xa	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):				
edical E			·				
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1 2							
/Mec	IF FEMALE:	23c. If was outcome of pregnan	2004				- 300
sian/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant   Live birth   2   Fetal	death 3 Ectopic p			23d. Date of deli	,
ysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		death 3 Ectopic p			23d. Date of deli	rvery Day Year
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hazel Irene Wellington 11:30 A. M March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford County 10 Roland Place Rel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 XF 66 277-38-0489 Ohio Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford County Bel Air 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or 3 Examiner must be r 10 Roland Place 21014 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Wool If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. White 3 Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Raymond Bartholow Maud Sylvetta Farmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra Mr. Charles Wellington (Son) 111 Colvarder Court, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages Murial 2 ☐ Cremation 3 ☐ Removal from State Belair Mem. Gardens March 20,2008 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air 69W ( 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months cancer tastatio ancreance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Exami sician and burial-trans Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 plonths? 1 ☐ Yes 2 ☐ No Day Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 TYes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an was ...
autopsy
pertormed?
Ves 2 100 death? 1 ☐ Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03-18-2008 S. SILIAS ALLAM. 602, S. ATWOOD ROAD, BELAIR MP 210/C

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

			Please	Type or Print							gible.	
			For State	State of Mar		epartment d C <i>ertificate</i>			-	0.0	200	00171
			Registrar  1. Decedent's Name (First, Middle, Las	1)		Jeruncale	or Deal		2. Date of Dea	leg. No	JUB	3. Time of Death
	Physici		Carlton	н.	Won	ıg		ĺ	Month March	Day	Year	
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	n, or Location		March ]		nty of Deat	08:56A M
			Greater Baltimore		Center	Tows	on			Ва	1timo	re
	uneral irector		210 10 40/3	7. Age (	(In yrs. last birth	Months D	ear If Und ays Hour	der 24 Hrs. s rs Min.	B. Date of Birth Sept.	17, 19	9. Birtl	hplace (State or Foreign untry) aryland
and	T A		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	or Location						10d. Inside City Limits
strong to the Maryland should be filed with the Maryland and Mental Hydiene.	ed other than "natural", or ltems 23a or 28a-f show event, the Medical Examiner must be notified at	Director	Maryland Baltimore	2	Baltimo							1 □Yes 2 □No
ath with	23a or ust be n		7813 Maple Avenue			10f. Zip Co			1	0g. Citizen o	of What Co	untry?
er de	Items ner m	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		<ol> <li>Was Decedent If Yes, specify</li> </ol>	of Hispanic Cuban, Mex	Origin? (Speci ican, Puerto Ri	fy Yes or No- can, etc.)		Race - Amei Black, White	rican Indian, e, etc.
ours aft	ıral", or I Exami	þ	1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	1▲ Yes 2 No If Yes, Give Year or Dates:	WW II	1 □ Yes 2 <b>X</b>		cify:		Spe	cify: A	sian
n 72 h	"nati edica	lete	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. D	ecedent's Usual O Give kind of work d ife. DO NOT use n	ccupation one during n	nost of working	,	16b. Kind of	Business/I	Industry
withii	r than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	<b>I</b>	achine I	,		1	Koppe	rs In	c.
al Hyo	othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mc	other's Name (i				
y ould b	arked atic e	은	Gin	Won				illie			Le	
d 2 sh th and	7 is m traum		19a. Informant's Name/Relationship (T)		ľ	Mailing Address (St						(ip Code)
t and 2 Health a	tem 2 other		Robert Wong (Broth 20a. Method of Disposition	ier)	20b. Place of D	3 Maple Anisposition (Name of	f	Baltimo		20c. Location		Town, State
Pages nent of	nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			crematory or other		2/2///			-	Maryland
permit.	Important: If item 27 is marked other than any Injury or other traumatic event, the Meonee.		21. Signature of Funeral Service License		Loudon	22. Name and A	ddress of Fa	cilityLoudo	on Park	Fune	nore, ral H	ome
1 85	드 등 등					3620 Wi	kens	Ave., I	Baltimo	re, M		
			23a. Part Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.		t enter the mode of	dying, such	as cardiac or I	respiratory arr	est,		Approximate Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	a. Sepsi								days
Exa	miner		Companie like like a conditions	Preuma	-							daye
pe	##	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a c		:					- 0	
xecuted	and al-transit	xamine	that initiated events resulting in death) Last	Due to (or as a c	consequence of)	:						
e pe e	/sician e buria	calE		4	,							
rtificat	ng phy as th	Medi	IE EENAN E.									
The law requires that the death certificate be e	ed by the attending physician detached for use as the burie	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 [ 4□Pregnant at tin 9□Unknown	Fetal death	3 ☐ Ectopic pregn 5 ☐ Other (specif					Date of deli Month	very Day Year
that	ned by detac		Part II. Other significant conditions co.	ntributing to death but r	not resulting in th	ne underlying cause	given in Pa	urt I.	23e. Did tob	acco use co	ontribute to	the cause of death?
aduire	s been signed t	ed by	Dementiq						1 □ Y∈	es 2 No	3 □ Pro	obably 4 □Unknown
law re	2 C I	Completed							24a. Was a		b. Were aut	topsy findings available ompletion of cause of
: The	cate h	Son							perform	ned?	death? 1 ∐ Yes	2 2 No
sician	certifi	Be	25. Was case referred to medical examiner?	fospital:				ace of Death (0	Check only on	e)		
Phys	er this eral di	٦. ا	1 Yes 22 TNo 7	28a. Date of Injury	2 ER/Outpa		Other: 4 njury at Work?	Nursing Home	e 5 🗆 Reside			ify)
Attending Physician: r death.	ir: Afte	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	<i>ear)</i> Inju		Nork? I∐Yes 2	i		,.,		
l or Atte	Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (	- At home, farm Specify)	, street, factory, off	се	28f	Location (St. City or Town	reet and Nur n, State)	m <i>ber</i> or Ru	ral Route Number,
To the Hospital or within 24 hours afte		Medical C	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Exami	sician: To the best of n ner: On the basis of ex and manner stated	amination and/d	leath occurred at the investigation, in	e time, date ny opinion, d	and place, and death occurred	d due to the ca	ause(s) and i	manner as e, and due	stated. to the cause(s)
To th withir	To th	Me	29b. Signature and title of certifier				ense numbe			9d. Date sigr		
	. \		Joron Stack				06119	19		March	. 20	. 2008
1	DX/	Ī	30. Name and address of person who co Jason Black, 65	ompleted cause of death	h (Item 23a) (Ty Charks	pe, Print) ST, SJ,	Fe 20	9. Tow	son, m	0 21	204	/
7	Stat Registra		Jason Black, 65 31. Date filed (Month, Day, Year) MAR 2 1 200	8 Registrar's	Signature	parle						

			1 - For Amend I	tem 2	State of N 29d per d	larylan <b>c.,g</b> 8	d / Depa 77,03/ —	artment of h	lealth a Death	and Me	ental Hy	giene Reg. No	2008	09	175
	Physic	an	1. Decedent's Name (First,	Middle, Las	t)						2. Date of De Month	ath Da	y Year	3. Time o	f Death
1	/Medi		Elizabeth M								larch .	10,	2008	2:13	PM M
	Exami	ıer	4a. Facility Name (If not inst	4b. City, Town, o		of Death		4c.	County of Death						
-	Cun avail		Montgomery  5. Social Security Number	6. Se			last birthday)	Olne	-	24 Hrs.	3. Date of Bir	th	Montgon		or Foreign
ì	Funeral Director		138-22-0397 Usual Residence of Decede	11	□м 2∏ F	81		Months Days	Hours	Min.	(Month, Da	y, Year)	6 New	nplace (State Intry) Jerse	
	land ow		10a. State 10b. Co			10c. Cit	y, Town or Lo	cation					T	10d. Inside C	ity Limits
	Mary Fled	to	MD Ba	altimo	ore		Cato	nsville						1 ☐ Yes	2 <b>∑</b> No
	h with the 3a or 28a st be noti	al Director	10e. Street and Number 719 Maiden	Choice	e Lane BF	18		10f. Zip Code	1228	-		10g. Cit	izen of What Cou USA	intry?	
980	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ 3 □ Widowed 4 □ Divo		12. Was Deceder Armed Forces 1 ☐ Yes 2 ② If Yes, Give Year or Dates	? <b>[</b> No		Nas Decedent of H f Yes, specify Cub		igin? (Spec n, Puerto R	ify Yes or No ican, etc.)	10	14. Race - Amer Black, White Specify: Wh	, etc.	
21215-0036	within 72 ho ene. than "natu he Medicai	Completed	(Specify only f	ighest grad	de completed) College (1-4o	5+)	(Give life. I	kind of work done OO NOT use retired	nation during mos d)	st of working	7		ind of Business/l	ndustry	
d 2	filed v Hygid Ither i			ddle. Last)			l h	ousewife	18 Moths	er's Name /	First Middle		n home		
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Maryland	2 should be f and Mental I is marked of raumatic eve	ပ္			ype. Print)	. <u>-</u>	19b. Mailir	g Address (Street				er. City o	or Town, State, Z	in Code)	
	C = 0 L		Robert White	/spot	ise										.228
Baltimore,	of L						lace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Da	te	20c. Lo	ocation - City or T	own, State	
Balti	permit. Pag Department Important: i any injury o			-1-		ector	22 S	Name and Addre	ss of Facili Comy	Board	655 W	. Ва	altimore	Stree	t
4	Physician		Immediate Cause (Final disease or condition	e, or comp List only o	ne cause on each	line.	n. Do not ente	er the mode of dyir	ng, such as			rrest,		Approxima Interval Be Onset and	tween Death
	/Medical Examiner	e.	Sequentiany list conditions, if any, leading to immediate		RUPT	URED	A80	OMINAL	AON	ILC A	NEUYSN	7- PA	ROBABLE	6400	25
68760,	ficate be executed physician and is the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ĺ	c Due to (or a	s a consequ	uence of):					***			
P.O. Box 6	death certifi e attending d for use as	Physician/Mec		t	1 ☐ Live birth	2 Fetal	death 3		/				23d. Date of deliv	,	Year
	requires that the een signed by th	þ	Part II. Other significant con	nditions co	ntributing to death	but not resu	ilting in the ur	derlying cause giv	en in Part I		_		se contribute to		
Division or Vital Records,	The larate has	Completed							<u>.</u> .		autor perfo	sy rmed?	death?	opsy findings ompletion of o	available ause of
VII:	ician: Th certificate ector, pag	Be	25. Was case referred to me examiner?	-	Loopitol			Tau		of Death (	Check only o	ne)			
0	Phys this c	၉	1 ☐ Yes 2 No		1 Ainpat			3 DOA	4 🗆 Nu					ify)	
u	ding J. After funer	ig	1 ☑Natural 5 ☐ Pe				Injury			- 1	d. Describe f	now injur	y occurred		
Division	e Hospital or Attending Physician: 24 hours after death: Funeral Director: After this certific etely filled in by the funeral director,	Certification:	Elementary Scoodary (0-12)   College (1-for 5+)   12   2	Street an vn, State	d Number or Rui )	al Route Nur	nber,								
_	To the Hospital or Attending Physician: Within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	(Check only 2 Med	ifying Phy ical Exami	ner: On the basis	of examinat	wledge, death ion and/or inv	occurred at the tir restigation, in my o	me, date an opinion, dea	nd place, an	d due to the d at the time,	cause(s) date and	and manner as	stated. to the cause(	s)
	To the within 2 To the I To the I Complet	Me	29b. Signature and title of ce	rtifier								29d. Dat	te signed (Month	Day, Year)	
			J. J.	aluc	July -			02.	3630			Mar	ch 10,	2008	
			30. Name and address of pe	rson who co	ompleted cause of	death (Item	23a) (Type, F	Print) ERZLK K	?0 AZ	13,	6 02711	ERI	BURB, M	P 20	877
	Sta Registr		31. Date filed (Month, Day, MAR 2 1	'ear)	32. Regist	rar's Signat	Cosses	,			_				

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ethel Christina Welsh 2035 PM 2008 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rosedale FRANKLIN SQUARE HOSPITAL CENTER Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, April 28, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🙀 F MaryTand 216-09-7937 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1339 Nautical Circle USA 21221 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No
If Yes, Give
Year or Dates: should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10wn Home or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Be Frank McFaul Ethel Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Mary Ellen Liebig/Daughter 1339 Nautical Circle Baltimore Maryland 21221 Health em 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/24/08 4 □ Donation 5 □ Other (Specify) Entombment Parkwood Cemetery Baltimore Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck. Inc. 5305 Harford Road Baltimore Maryland Wilto Kustra 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed death? 1 ∐ Yes certificate 2□ No To the Hospital or Attending Physician; 25. Was case referred to medical director Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral ( 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 00065242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md 21237 9000 FRANKLIN SQUARE DR Balto S. SMITH DR TAMAS 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

Welsh

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 Month **Physician** March 4, Robert Anderson 2225 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Medical Center Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ★ M 2 🗆 F 63 Director 026-32-5929 Apr 26, 1944 Boston, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11322 Cherry Hill Road 20705 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 DYes 2 No 1979− If Yes, Give Year or Dates: 1984 1 XNever Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Materials Facilities Supply U.S. Air Force 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Charles M. Anderson Conjetta Mary Stauff traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 3516 Duke Street, College Park, MD Joan Ford - Sister Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If it
any injury or o
once. 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Metropolitan Crematory 3/16/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Dasc Zanning Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical UMONIA Examiner Sequentially list conditions, if any leading to finite list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OBSTRUCTIVE PULMONARY Examine CHRONIC certificate be executed and burial-trar Due to (or as a consequence of): APNOEA Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Po Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. \$ INSUFFICIENC 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2□1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident after death in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 To the Hospital of within 24 hours at To the Funeral D filled Hospital 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Compared in the time, date and place, and due to the cause(s) and for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 2/5/2008 29b. Signature and title of certifier AAMIM, MD

UN 1941 Star

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 7 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAHD SHAMIM MD . WAIHTINGTON ADVENTIST HOSP TAKEMA

31. Date filed (Month, Day, Year)

32. Registrar's Signature.

PARR MD - 20 91 2

			<b>1 - State Amend Item 21 P</b>	te of Maryland er fn, g878,	04/01/08 Certific	ent of H <b>dhb</b> <i>ate of t</i>	lealth ai D <i>eath</i>	nd Menta	Hygier Reg. 1	ne vo. 2 0 0 8	09178
ľ	Physic		1. Decedent's Name (First, Middle, Last) $Arthu$	r W. Alle	bach			Mon		Day Year	3. Time of Death 5'17A M
	/Medi Examii		4a. Facility Name (If not institution, give street a	and number)	4b. C	City, Town, or	Location of			4c. County of Death	mico
i	Funeral Director		5. Social Security Number 214-46-3813 6. Sex	7. Age (In yrs. le	ast birthday) If Ur Yrs. Mont	nder 1 Year ths Days	If Under 24 Hours	Hrs. 8. Date (Mo)	of Birth Day, Year 13,1	9. Birthp	place (State or Foreign
	death with the Maryland ms 23a or 28a-f show r must be notified at	٥ľ	Usual Residence of Decedent  10a. State	10c. City	, Town or Location	eder	a1sbu	rø			10d. Inside City Limits 1 □ Yes 2 🕱 No
	vith the Na or 28a-	Director	10e. Street and Number	1 D 1		Zip Code				Citizen of What Cou	-
	r death v ems 23a	Funeral	3919 Houston Bran  11. Marital Status 12. Wa	ICD KOAD  IS Decedent Ever in U.S  med Forces?	S. 13. Was D		21632 ispanic Origi an, Mexican,	n? (Specify Yes Puerto Rican, e		14. Race - Americ Black, White,	can Indian,
5-0036	ours after rral", or ite Examine	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ If Y	]Yes 2[∏]No 'es, Give ar or Dates:	1 □ Ye	s 2DXNo	Specify:			Specify: W	hite
1215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		eleted) llege (1-4or 5+)	16a. Decedent's l (Give kind o. life. DO NO Mainten	f work done o T use retired	durina most d	of working		Kind of Business/In	•
nd 2,	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	Be Co	10   17. Father's Name (First, Middle, Last)						Middle, Maid	len Surname)	
nore, Maryland	should tund Ment marked	2	Mahlon Allebach  19a. Informant's Name/Relationship (Type. Pri.	int)	19b. Mailing Add	ress (Street					
, R	1 and 2 s Health ar em 27 is		Marybell T. Alleb			ousto		ch Rd.	, Fe	deralsbu	rg, MD
altimore,	Pages 1 nent of H nt: If ite		20a. Method of Disposition  ↓ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	ol from State	emetery, crematory 11estown	or other place				,	,
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee  Roman G. Coale	, CFSP	22. Nam Fede:	e and Addre ralsbu	ss of Facility	Frampto 21632	om Fun	eral Home	, P.A.
		0. 1	Immediate Cause /Final					,			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)			44	Na	CARCI	NOW	A	
1		ner	Sequentially list conditions, b. cause. Enter Underlying	Due to [or as a conse <u>]</u> u	ience ofic						
o,	execute an and rial-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						<del></del>
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.O. Box (	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	□Live birth 2 □ Fetal □Pregnant at time of de	death 3 ☐Ectop		/			23d. Date of deliv Month	very Day Year
0	ires that the signed by the detaction	þ		ng to death but not resu	llting in the underlyi	ng cause giv	en in Part I.	236		5.7	
Recor	requestion requestions	Completed						248	autopsy	24b. Were aut	opsy findings available ompletion of cause of
/ital	clan: Ti ertificate ctor, pa	Be Co	25. Was case referred to medical examiner?	Roman G. Coale, CFSP  Federalsburg, MD Tambton Funeral Home, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, induct, or heart failure. List only one cause on each line.  Indiate Cause (Final sie or conditions are conditions)  Indiate Cause (Final sie or conditions)  Indiate C	2 No						
n or \	ng Physician: fter this certific neral director,	P	1 ☐ Yes 2 No Hospita	1 L/mapatient 2 Lit	ER/Outpatient 3 28b. Time of Injury	DOA Oth 28c. Injui Wor	4 LI Nuis				ify)
Division or Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certification:	2 Accident investigation	e. Place of injury - At hor building, etc. (Specify	me, farm, street, fa		Yes 2□N	28f. Loc	mpt om Funeral Home, P 632  Prespiratory arrest, Applications  23d. Date of delivery Month Day  23e. Did tobacco use contribute to the call yes 2 No 3 Probably  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes	ral Route Number,	
	Hospital 24 hours a Funeral I	Medical C	(Check only 2 Medical Examiner: O	To the best of my known the basis of examinated manner stated.	wledge, death occu tion and/or investig	rred at the ti ation, in my	me, date and opinion, deat	d place, and due th occurred at th	e to the cause e time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	)		29c. Licens				-	
			30. Name and address of person who complete	ed cause of death (Item	23a) (Type, Print)	De	18 50	110	-	3/5/0	8 up 21802
			CHUMAN WARES	COAST. AV 832. Registrar's Signat	Hospick	8.6	BOX 1	733 2	Alis	Bung .	20812 an
	St Regist	ate	31. Date filed (Month, MAR <sup>ar)</sup> 1 0 200	832. Hedistrar's Signat	Luie A	MA				,	

DHMH 17 Rev 1/2001

		For State of Ma	aryland / Depa <i>Cel</i>	artment of H rtificate of I			Jiene Neg.No.? ↑↑↑	00179
Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Augustus L. Brown				2. Date of Dea Month March 4,	Day Year	3: Time of Death
Examin Funeral Director	-	4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospital  5. Social Security Number 225–28–3342  6. Sex 1 M M 2 □ F 86	ə (In yrs. last birthday) Yrs.	4b. City, Town, or Clinton  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 4, 1	r, Year)   Co	rge <sup>1</sup> s thplace (State or Foreign
D	_	Usual Residence of Decedent  10a. State 10b. County  Viscolinia Homoton	10c. City, Town or Lo	ocation			0001	10d. Inside City Limit
with the Ma 3a or 28a-f s 1 be notified	Director	Virginia Hampton  10e. Street and Number  1705 She11 Road	Hampton	10f. Zip Code 23661			10g. Citizen of What Co	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never Married 1 Never Narried 1 Narr	No WW II	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Bla	te, etc. ack
d within 72 h giene. er than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give		ation during most of worki d)	ng	Ship Buildin	
ould be file Mental Hy, larked othe	To Be C	17. Father's Name (First, Middle, Last) Frederick Brown			Julia	Unknown		
es 1 and 2 sh of Health and fitem 27 is m r other traum		19a. Informant's Name/Relationship (Type. Print)  Karen Brown/Daughter  20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □ Removal from State	9709 <sup>s</sup> 20b. Place of Dispo cemetery, cre	Treyburn Ct position (Name of matory or other place	. Ellicott (		er, City or Town, State, yland 20142  20c. Location - City or	
ermit. Page epartment on nportant: If ny Injury or nce.		1 □ Burial 2 Micremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify)  21. Signature Funeral Service & Compared Compa		2. Name and Addre	3/6/08 ss of Facility Geo. L1 Rd. Oxon	P. Kalas	Edgewater, Mass Funeral Home	
Physician and hubician and the private provided in the private transit the private transit to the private transit to the private transit to the private transit transi	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):  a consequence of):	otic can	WO16 UASE	w/m	Dicess	Approximate Interval Between Onset and Death
death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause giv	en in Part I.		obacco use contribute t Yes 2 ☐ No 3 ☐ F	to the cause of death? Probably Unkno
The law ate has b page 2 sl	Completed					24a. Was autor perfo 1 Yes	prior to rmed? death?	
Attending Physician: The death. rector: After this certificate by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?    Yes   2	ry at rk? Yes 2 □ No	me 5 Resident	dence 6 Other (Sp. now injury occurred			
Hospital or Atten 4 hours after deatt Funeral Director: tely filled in by the		4 Homicide determined 288. Place of my building, et		th occurred at the ti	me, date and place,	City or Tov	vn, State) cause(s) and manner a	as stated.
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one) Medical Examiner: On the basis of and manner st		29c. Licens			29d. Date signed (Mor	
Sta Registi		30. Name and addres rof person who completed cause of	death (Item 23a) (Type	Print)	N/4#/	03 F7	Mashing	De MD2

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 3, 9008 **Physician** Delores Burke Bowden 11:49  $A^M$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 3413 Weltham Street Suitland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Days 245-56-5359 Director 1937 June 7. North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if then 27 is marked other than "natural" or how many or other trainment. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State MD 1 ☐ Yes 2€XNo Prince Georges Suitland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3413 Weltham Street 20746 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Black Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Specialist U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Burke Catherine Blue 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffery Bowden - son 6921 Briarcliff Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 3/10/08 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3ell & Johnson Funeral Home, P. A. 21. Signature of Funeral Service Li 6503 Old Branch Ave., Temple Hills, MD 20748 Parti. Enter the disease, or co cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is cause on each line. 23a. Pa Immediate Cause (Final CardioVasen **Physician** Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infiliating cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Just to for selections agree of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1∐ Yes Hospital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examined: 26. Place of Death (Check only one) examinor? Hospital: Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

State

MAR 06 Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signa 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Yareh

2008

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Maryla	-	tificate of L		, ,	Jierie leg. Nost (1 (1 (1	00101
	Physicia	en en	1. Decedent's Name (First, Middle, Last)					Date of Dea     Month		3. Time of Death
	/Medic		EDWARD	PETER	BROW			MARCH	I 2008 ear	5:22 AM
	Examin	er	4a. Facility Name (If not institution, give str  LAUREL REGIONAL	,			Location of Death		4c. County of Dea	
	Funeral Director	0	083-30-3507	7. Age (In yr 69	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JULY 5	, Year) C	thplace (State or Foreign ountry) W YORK
	and w t		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation	· · ·			10d. Inside City Limits
	Maryl -f sho ied a	tor	MD PRINCE GEO	PCF'S	LAUREI					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	KGE 5	LAUKEL	10f. Zip Code			l 0g. Citizen of What C	ountry?
	th with		501 MAIN STREET # 2	221		2070	07		USA	
	ems er mu	Funeral	11. Marital Status	. Was Decedent Ever in Armed Forces?	1 1	Vas Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am-	
5-0036	be filed within 72 hours after death with the Maryland Hyglene.  Independent than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Merical Examiner must be notified at	ρ	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No A I If Yes, Give Year or Dates:	RMY	□Yes 2No	Specify:	,		BLACK
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7	withir ene. than than	mc	Elementary/Secondary (0-12)	College (1-4or 5+) YR		NTENANCE			ው ተ <i>ህ</i> ለጥር	
מ	filed Hygi other ent, tl	a)	17. Father's Name (First, Middle, Last)	IN	MAI		18. Mother's Name	(First, Middle,	PRIVATE Maiden Surname)	· · · · · ·
<u>a</u>	lid be lental rked o	To B	EDWARD BROWN SR.				LILLIAN	AGUSTU	S	
ary	2 should be and Menta is marked raumatic ev		19a. Informant's Name/Relationship (Type	. Print)					r, City or Town, State,	Zip Code)
Ξ,	and 2 salth a n 27 l		SHIRLEY Brown/WIFE		501	MAIN STRI	EET # 221	LAUREL	,MARYLAND	20707
o e	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer		. Place of Dispos cemetery, cren	sition (Name of natory or other place	9)	Date	20c. Location - City or	Town, State
Ē	. Pages tment of I tant: If Ite jury or o		4 □ Donation 5 □ Other (Specify)			LN CEMETE		I .	BRENTWOOD,	
Baltimore,	permit. Pages 1 and 2 should bu Department of Health and Mente Important: If Item 27 Is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	ce h		Name and Addres 474 LANDO			ENKINS FUN ER MARYLAN	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the de cause on each line.	ath. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arr	rest,	Approximate Interval Between
	Physician	9 /	Immediate Cause (Final disease or condition	MYOCARDI						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
300	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					
	rificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of).					
08/00,	sician buria	E E			Due to (or as a consequence of):					
200	ficate g physis the	edical	a							
X 0 0	h cert		IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome pf preg		Fotonio nue anono:			23d. Date of de	livery
_	that the death cert ed by the attendin detached for use	Physician/IV	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
<u>,</u>	that the bed by detact		Part II. Other significant conditions contri	buting to death but not re	esulting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ecoras	we requires that s been signed by should be deta	ed by						1 <b>X</b> Y	es 2□No 3□P	robably 4 Unknown
ည	> 0 %	Completed						24a. Was a	24b. Were a	utopsy findings available completion of cause of
ב	The law ate has b	ĕ						perfor	med?   death?	s 2 🛛 No
V I Call	clan: ertific actor,	Be (	25. Was case referred to medical examiner?				26. Place of Death			
5	Physiclan: r this certific ral director,	ို	1 ☐ Yes 2 No		XER/Outpatient		4 LI Nursing Ho	•	ence 6 □Other (Spe	ecify)
	ding F	ion:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	rat ? ∕es 2 □ No	28d. Describe h	ow injury occurred	
2	Attending r death. ector: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At	home, farm, stre			28f. Location (S	treet and Number or F	ural Route Number.
2	al or / s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)			City or Tow	n, State)	,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical (	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	lan: To the best of my k r: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the or	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th	M	29b. Signature and title of certifier	7 //-		29c. License	number	2	29d. Date signed (Mon	th, Day, Year)
			Vany	Hee	1	D532	35		MARCH 4,	2008
L	(5)		30. Name and address of person who com							
			DARRYL HILL MI			AVENUE LA	AUREL, MA	RYLAND	20707	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 6 2008	32. Registrar's Sig	Least )					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 Earline Cook Bagnall March 7:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Director 424-20-0170 May 8, 1915 Alabama Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No Director Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Old New Market Road 21774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) the Mathematician Applied Physics Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jesse Lee Cook Parrie Gus Darrough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra Bonita A. "Scotty" Sherman 5807 Green Valley Road, PO Box 236, New Market, Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation S □ Other (Specify) Metropolitan Crematory 3/7/2008 Alexandria, Virginia 21. Sign Jure of Fundral Servi 22. Name and Address of Facility Molesworth-Williams Funeral Home Licensee 26401 Ridge Road, Damascus, Maryland an 23a. Part1. Fill er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate rause inal disease or co ditio resulting in dea **Physician** Dheumania /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and I-tran Due to (or as a consequence of) physician a Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 2No the 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 21 No Hypertensier 1 ☐ Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 28a. Date of Injury 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Deal 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie: Medical (Check only one) and manner stated.

State

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Hiron N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

homas

2008 Signature

29c. License number

Fredonich

29d. Date signed (Month, Day, Year)

01702

		•	1 - State Registrar	State of Ma		partment of F e <i>rtificate of</i>			ene 008	09183
	Dhyciai	an.	1. Decedent's Name (First, Middle, Last)	-	0201	100		2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		PEARL	I	BRUN			March 8	3, 2008	3:30 p.m.
	Examin Funeral Director	er	4a. Facility Name (If not institution, give stress St. Mary's Nursing  5. Social Security Number 6. Sex 1 M	Center	e (In yrs. last birthde 82 Yrs.	Leo  If Under 1 Year  Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 10/21/192	(ear) C	
	D		Usual Residence of Decedent							
	arylar show	-	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	28e-f	ecto	Maryland St. Mary  10e. Street and Number	's		Mechanic 10f. Zip Code	sville	100	g. Citizen of What C	
	a or	Funeral Director					1659	100		•
	ne 23	era	42015 Gibson Drive  11. Marital Status 12.	Was Decedent E	Ever in U.S. 1	3. Was Decedent of H	Hispanic Origin? (Spe	ecify Yes or No-	United S	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural" or Iteme 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Ď	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ N  If Yes, Give  Year or Dates:	lo	If Yes, specify Cub 1 ☐ Yes 2 💢 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	White
20	72 hornatur	Completed	15. Decedent's Educat (Specify only highest grade c		16a. De	cedent's Usual Occupive kind of work done	pation during most of worki	ina 16	6b. Kind of Busines	s/Industry
2	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use retire	d)			
2	fled w flygier her th		12 17. Father's Name (First, Middle, Last)			Homemake	18. Mother's Name	/First Middle Ma	Own Ho	me
Maryland	ntal Hed of	Be						ine Rhode		
7	should ad Me mark matic	2	William Schultz  19a. Informant's Name/Relationship (Type)	Print)	19b. Ma	ailing Address (Street				Zip Code)
Z S	od 2 s lith ar 27 is r treu		George Brunst / Hus	hand	420	015 Gibson	Drive M	echanicsy	ville. MD	20659
re,	s 1 au if Hea item othe		20a. Method of Disposition		20b. Place of Dis	sposition (Name of trematory or other pla			Oc. Location - City o	
E O	Page nent o int: If		1X Burial 2 ☐ Cremation 3 ☐ Rem  *4 ☐ Donation 5 ☐ Other (Specify)	noval from State		n Cemetery		2008	Solon, Oh	io
Baltimore,	permit. Departmimporta		21. Signature of Funeral Service Licensee	45		22. Name and Addre				
<u> </u>	89589		Kyle S. Simons							20650-0279
142		,	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused cause on each lin	the death. Do not not	enter the mode of dyn	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		noea.					
Ų.	/Medical Examiner		resulting in dealth)		a consequence of):					
	4	- a	Sequentially list conditions, if any, leading to immediate		a consequence of):					
	uted	min	cause. Enter Underlying Cause (Disease or injury that initiated events	As	stoma	•				
Ć,	execting and training the same of the same	Examiner	resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be executed physician and the burial-transit	dical	d							
Φ	ntifica ng ph s as th	Med	IF FEMALE:						1	1
.O. Box	that the death certific ed by the attending p detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
s, P	s that ned b e deta	y Pt	Part II. Other significant conditions contri			,	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rg	w requires that been signed be should be det		Paulein	SONS	DIS	ease.		1 ☐ Yes	2 No 3 1	Probably 4 Munknown
Record	e la has je 2	Completed						24a. Was an autopsy performe	prior to	
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					n (Check only one,		
of V	N VI TO	2	1 ☐ Yes 2 ☐ No Hos	pital: 1 🗌 Inpatie		HERIT 3 DOA	and the state of t		ice 6 □Other (Sp	pecify)
ion	ding After fune	ation;	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Da)	ry 28b. Time y Year) Injui	y Wo	ry at rk? ]Yes 2 □ No	28d. Describe how	v injury occurred	
Division	i Sire	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.		street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine		examination and/o					
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licen			d. Date signed (Mo	
)			Lain	, J.	M.D.	D 6	0888		03/10/	08.
			30. Name and address of person who com							
			Rakhi Krishnan, M.		Three No	otch Road,	Hollywood	d, Maryla	and 20636	
0.80	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 2 2008		ars Signature	9				

		1 - For State Registrar	State of Maryland	•	artment of F tificate of		-	giene	8 09184
Physic	ion	1. Decedent's Name (First, Middle, Last	)				2. Date of De Month	path Day Yea	
/Med			lice Baker				March	7, 2008	
Exami	ner	4a. Facility Name (If not institution, give	street and number)			or Location of Dear	th	4c. County of D	
		Homestead Manor 5. Social Security Number 6. Se	x 7. Age (In yrs. las	t birthday)	Dento		8. Date of Bir	th Caroli	Birthplace (State or Foreign
Funeral Director			M 20√F 90	Yrs.	Months Days	Hours Min	. (Month, De June 27	ay, Year) 1917 Mc	Country) aryland
		Usual Residence of Decedent							
rylan		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits 1,☑ Yes 2 ☐ No
Be-f a	cto	Maryland Caroli	ne Î	Entor		_·~			
dith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
s 23e	ral	509 Franklin Stre	et 12. Was Decedent Ever in U.S.	10.5	21629 Was Decedent of H				tes of Americ
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23e or 28e-1 show inportant or other treumatic event, Ite Medical Examinar must be notified at ence.	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 ☐ Yes 2 ☑ No	13.	f Yes, specify Cub	an, Mexican, Puer	rto Rican, etc.)		/hite, etc.
irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Specify: Co	aucasian
2 hou	ted	15. Decedent's Edi		16a. Dece	dent's Usual Occup	nation	orking	16b. Kind of Busine	
thin 72 hours affile.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	nkiiig		
ad will	Son	11 HS Grad.			Homemak			Home	
al Hy doth	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
d 2 should be filed within the and Mental Hygiene. 77 Is marked other then treumatic event, the	2		Richard Noble			L		llen Higni	
2 sh and Is m		19a. Informant's Name/Relationship (T	1		-			er, City or Town, Stat	
l and lealth im 27		J. Alan Baker  20a. Method of Disposition	Son 20b Pla				Columbia	2. Maryland 20c. Location - City	
Dermit, Pages 1 s Department of He mportent: If Item eny injury or othe		1∠Burial 2 ☐ Cremation 3 ☐	Hemovai from State I		nsition (Name of matory or other pla				
t. Pa rtmen rtent:		'4 □Donation 5 □Other (Specify			Cemetery			Concord,	'larykana
permit, Departr Import eny in	4	21. Signature of Funeral Service Licens		1	Name and Address Noone Fun	eral Hom	re, P.A.	5 1	0 1 277 30
		23a. Part1. Enter the dise to or comp	lications that caused the dealt	Do not ent	2 South	Second S	treet. L	Jenton, Ma prest	rykand 21629 Approximate Interval Between
Physician /Medica Examiner	1	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter the arrival of the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque  c.	nce of):	rtery	Craec			
certificate be executed rights physician and use as the burial-transit	cal	IE EEMAI S.	Due to (or as a conseque  d					and Date of	deliana
death death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Fetal of 4□ Pregnant at time of dea 9□ Unknown	eath 3[	Ectopic pregnand Other (specify)	У		23d. Date of Month	Day Year
w requires that the been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death but not result	ing in the u	nderlying cause gi	ven in Part I.		. /	te to the cause of death?  Probably 4 □Unknown
The law i	Completed						24a. Was auto perf 1 ☐ Yes	ormed2   deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbole \text{No}\)
OI VICAL F Physicien: Th this certiticate ral director, pag	To Be	1 1 105 2 1VO		R/Outpatie	IT 3 DOA	her: 4 Nursing	Home 5 Res		Specify A 3 3 1
Attending Ph r death. ector: After the by the funeral	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	8b. Time of	M 1	ork? ]Yes 2 □ No			r Rural Route Number,
To the Hospitel or Attent within 24 hours after deati To the Funerel Director: completely tilled in by the	Certif	4 Homicide determined	building, etc. (Specity)				City or To	own, State)	
24 ho Fund	edical	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Exam	ysician: To the best of my know iner: On the basis of examination and manner stated.	on and/or in	vestigation, in my	opinion, death occ	curred at the time	, date and place, and	due to the cause(s)
To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (M	fonth, Day, Year)
⊢≯řŏ				MD	00	00532	55	3/11/09	8
		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)				
		Melinda B.	136 J	-edr	um Ar	e Pr	eston	WDO	21655

State of Manyland / Department of Health and Mantal Hydiana

			For State	State of Mary		Department of H Certificate of I			001	20	00105
			Registrar  1. Decedent's Name (First, Middle, Las			COMMODIC OF		2. Date of Dea		10	3. Time of Death
	Physicia	_	Dorothy Lucil	le Baumgai	dner			Month 3 / 1 5	/ 2008	Year	10:15 AM
Mary.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of	f Death	
		-	Citizens Nurs	ing Care &	k Reh	ab Freder			Fred	lerio	k
, pre	Funeral		Social Security Number     6. S		n yrs. last biri	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	9. Birthplac Country	
ia.	Director		214-10-1315	92	+	Yrs.		7-1-1	913		MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Towr	n or Location				100	d. Inside City Limits
	Maryl f sho ied a	ō	MD Freder	ick	Fre	derick					1 XYes 2 No
	the notif	Director	10e. Street and Number		-	10f. Zip Code		1	0g. Citizen of Wh	nat Country	y?
	h with	al D	1900 Rosemont	Avenue		21701			USA		
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race	- Americar White, etc	
9	after or Ite	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕱 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	, ,	Specify:		
21215-0036	ours ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	10-	Decedent's Usual Occup	etion			Whit	
5	"nat	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	10a.	(Give kind of work done life. DO NOT use retired	during most of work d)	ring	16b. Kind of Busi	mess/muu	stry
12	withii lene. than he M	Junc	Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		Book Keepe			Hardwa	re R	Retail
9	filed Hyg other ent, t		17. Father's Name (First, Middle, Last)	)				e (First, Middle,	Maiden Surname		
lan	lid be lental rked (	To Be	Harry D. Baum	gardner			Margar	et Wisi	ner		
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (	Type. Print)	19b	. Mailing Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, S	tate, Zip C	(ode)
Σ,	and 2 salth a n 27 l		Donna Smith	Niece	6 (	012 Fair 0	aks Dr.	Frede			
ore	les 1 of H∉ of Itten		20a. Method of Disposition 1 Burial 2 🖾 Cremation 3 🗔	Removal from State	20b. Place of cemeter	Disposition (Name of ry, crematory or other place	ce)	Date	20c. Location - C	City or Tow	n, State
Ĕ	Pag ment ant:		4 □ Donation 5 □ Other (Specif	y)	Smitl	hsburg Cem	. 3/1	7/2008	Smiths	burg	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Filheral Service Liger	( )		22. Name and Addre	ss of Facility Ke	eney &	Basfor	d P.	A. F.H.
	O		Julion		176	106 East	Church	St Fr	<u>ederick</u>		
			3a. Part. Enter the disease, or com shock, or heart failure. List only					or respiratory arr	est,	ĺ	Approximate nterval Between Onset and Death
a	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.		Vasculm	DISEASE				
	Examiner			Due to (or as a co	onsequence	of):					
	<b>美</b> 溪	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	onsequence	of):					
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	exec an and rial-tra	Еха	resulting in death) Last	Due to (or as a co	onsequence	of):					
68760,	ficate be executed physician and the burial-transit	dical		d						_	
	ng ph as th	(I)	IF FEMALE:								_
Вох	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 ☐ Live birth 2	∃Fetal death		y		23d. Date Mon	of delivery	y Day Year
0.	ne de the art hed for	sici	1 Yes 2 No	4⊟Pregnant at tim 9⊟Unknown	e of death	5 ☐ Other (specify) _					
<u>α</u>	w requires that the death certif been signed by the attending should be detached for use a		Part II. Other significant conditions of	contributing to death but n	ot resulting in	n the underlying cause giv	ren in Part I.	23e. Did to	bacco use contrib	bute to the	cause of death?
ds,	signe d be	d by	CORDATANY Ante	y Disease				1 🗆 Y	es 2⊠No 3	3 ☐ Proba	biy 4 ∐Unknown
Record	v requestions	Completed	It who rtensin	5				24a, Was a	an 24b. W	/ere autops	sy findings available
Re	e la has	dmo	Renal NSUR	2				autop	sy pr rmed? de	rior to comp eath?	pletion of cause of
ta	i <b>clan</b> : Th certificate ector, pag		25. Was case referred to medical	recy			26. Place of Dea			□Yes 2	2□ No
or Vital	Physician: this certific	To Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient	2 ☐ ER/Ou	utpatient 3 DOA Oth	or.		lence 6 Othe	r (Specify)	
10	ding Phy h. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Y		Time of 28c. Inju			ow injury occurre		
jo	Attending r death. ector: After by the fune	atio	Natural 5 Pending investigation	n			Yes 2 □ No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			arm, street, factory, office		28f. Location (S City or Tow	Street and Numbe In, State)	r or Rural	Route Number,
Ω	ital ours af		4 10 0 0 0 0	4		- d4b444			(1) 1		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		nysician: To the best of r miner: On the basis of ex and manner stated	amination ar						
	o the rithin i o the omple	Mec	29b. Signature and title of certifier		1	29c. Licens	se number		29d. Date signed	(Month, D	ay, Year)
	⊢ \$ <b>⊢</b> ŏ		Cineue	B. Cusua	nl	Du	10307	MO	17-m	AL OS	5
			30. Name and address of person who	7	h (Item 23a)						-
			Dr. Eugene B.				ssumtow	n Pk F	rederic	k MI	21702
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	A 1075					
	Regist	rar	MAR 2 1 2	2008 Region	J.J.	A1344)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** THEODUS COOK MARCH 2008 10:15 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY SHADY GROVE HOSPITAL ROCKVILLE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F CLEVELAND, OHIO Director FEB 11 1960 48 278-60-0965 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show notified at 1 X Yes 2 No PRINCE GEORGE'S BOWIE Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code pe e USA "natural", or items 23a edical Examiner must b 20720 4406 HUNT CHASE DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: BLACK þ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ENTREPRENEUR SELF-EMPLOYED 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental THEODUS COOK **EMMA JENKINS** SR. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unit of Health a.
nt; If item 27 is a 4406 HUNT CHASE DRIVE BOWIE, MARYLAND 20720 JANET S. COOK/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) LAKEMONT MEM. GARDENS 3/8/2008 DAVIDSONVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME wan frederick 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner rdiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be 1 Yes 2 No 3 Probably 45 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? page Chronic 1X Yes 2 □ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of D005442 completed cause of death (Item 23a) (Type, Print) Croug Colliver C 30. Name and addr Medical 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2008

MAR 1 0

			For State Registrar	State of	f Marylar				ealth : Death		lental Hy	giene Reg. No.	20	0.8	กจ	187
b	900		Decedent's Name (First, Middle, Las	t)							2. Date of D	eath		00	3. Time of	Death
	Physicia		HO SUN			Ct	MAN	1-			MONTH	Day		rear	10:3	, AM
	/Medic		4a. Facility Name (If not institution, give	street and nur	nber)	(			Location		MAKCH	7	County of		10.5	
)	Examin	er		OPKIN		DITAL				_	177					
-	Euparal		5. Social Security Number 6. Se		7. Age (In yrs.		If Unde		ORE If Under		8. Date of B	irth		9. Birthr	place (State o	r Foreian
	Funeral Director		220 59 2072 1	<b>X</b> M 2□F	52	Yrs.	Months	Days	Hours	Min.	(Month, E	ay, Year)	55	Coùi S	ntry)	
			Usual Residence of Decedent								OULY	0 19	22		• _KUKI	JA
	/lanc		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	10d. Inside Ci	ty Limits
	Mar- -f sh fied	to	MD HOWARD		E.	LKRIDO	ΞE								1 XYes	2 No
	r 28a	ec	10e. Street and Number				10f. Zi	Code				10g. Citi	zen of Wh	at Cour	ntry?	
	3a o	0	6652 Hunter R	d			2	1075				50	UTH	KΟI	DΕΛ	
	after death with the Maryland or Items 23a or 28a-f show miner must be notified at	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.1	Nas Dece	dent of Hi	spanic Or	igin? (Spe	ecity Yes or N		14. Race	Americ	can Indian,	
0	or Ite	E	1 ☐ Never Married 2 Married	Armed Fo	2 No						Rican, etc.)			White,		
0000	urs a al', c Exan	Ď	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e ates:		1 ☐ Yes	2LX No	Specify:				Specify:	AS.	LAN	
2	filed within 72 hours Hygiene. Nther than "natural", snt, th⊮ Medical Exa	Completed	15. Decedent's Ed			16a. Deced	dent's Usu	al Occupa	ation	at of work	im a	16b. Ki	nd of Bus	ness/In	dustry	
<u></u>	hin 7	ble	(Specify only highest gra	College (1	-4or 5+)	life. I	DO NOT L	se retired	luring mos )	st of work	my					
7	d wit	PO.	12		,	Prop	rie	tor				PR	CAVI	'E		
2	othe vent,	Be	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	e (First, Middl	e, Maiden	Surname	)		
<u>a</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	TO E	IN SUNG C	HANG					Κi		SOOK	SY	NG			
<u>a</u>	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	g Addres	S (Street a	and Numb	er or Rur	al Route Num	ber, City o	r Town, S	tate, Zip	Code)	
2	1 and 2 Health a tem 27 Is		EUN HO CHANG/	WIFE		6652	2 HU	NTER	RD	ELK	RIDGE	MD	2107	75		
ב ב	of He of He r oth		20a. Method of Disposition		1 .	Place of Dispo	sition (Na	me of other plac	e)	1	Date	20c. Lo	cation - C	ity or To	own, State	
allino	permit. Pages Department of I Important: If its any Injury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State	RBECK	-			3/8/	8	OLN	EY	MD		
7	mit.	Ηĩ	21. Signature of Fun all Service									HTND	S FI	INE	RAL SI	ERV
ŏ	permit Depar Impor any Ir once.	4		track	0 .						PPER .				207	
			23a. Part1. Enter the disease, or comp	lications that c	aused the deal										Approximat Interval Bet	е
	Physician	3 4	shock, or heart failure. List only immediate Cause (Final	_										4	Onset and I	Death
)	/Medical		disease or condition resulting in death)	d.	or as a conseq	mence off.								-	IWE	<u> </u>
	Examiner			150	HEM		OW	F. I							11/2 W	VEEK
		ē	Sequentially list conditions, in cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	or as a conse	_	011							-	1 12 1	
	uted ansit	튵	Cause (Disease or injury													
,	n and	Examiner	resulting in death) Last	C. Due to (	or as a conseq	juence of):										
0070	icate be executed physician and s the burial-transit	dical		d												
0	ficate phy s the	g		u												
200	certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come pf pregn	ancy							23d. Date	of delive	erv	
ŏ	atter for t	cial	in the past 12 months?		irth 2 Feta		]Ectopic p ] Other (s						Mont			Year
į	the c y the	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno			,	- // -								
L	sIclan: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to de	eath but not res	ulting in the u	nderlying	cause give	en in Part	l.	23e. Did	tobacco u	se contrib	ute to t	he cause of d	leath?
necorus,	uires sign Id be	d b	MMUNOSUPPRESS	ION							1 🗆	] Yes 2[	□No 3	B □ Prob	babiy 4 🔀	Jnknown
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	cate pag	Ŝ									1□ Yes	formed? 2 No	1 [		2 No	
N II d	lclar Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Oth		e of Deat	h (Check only	one)				
5	this aldir	၉	1 ☐ Yes 2 No			ER/Outpatier			4 ∐ N		me 5 Re				fy)	
	ding Phys	e l	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date ( (Mont	th, Day Year)	28b. Time of Injury		28c. Injury Work		İ	28d. Describe	how injur	y occurre	d		
10  2  0	tend eath tor:	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2□	-					20.00	
2	or At ter d lirec n by	Certification:	4 ☐ Homicide determined	Zoe. Place	of injury - At h ng, etc. <i>(Sp</i> ec <i>i</i> i	ome, farm, str fy)	eet, facto	у, опісе			28f. Location City or To	(Street an own, State	d Number )	or Run	al Route Num	iber,
3	ors al			N.						- 1						-
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph	iner: On the ba	asis of examina	owledge, deat ation and/or in	n occurred vestigatio	l at the tin n, in my o	ne, date a pinion, de	nd place, ath occur	and due to the red at the time	e cause(s) e, date and	and man d place, ar	ner as s nd due t	stated. to the cause(s	3)
	the hin 2 the mplei	Med	one)	and man	ner stated.	· · · · · · · · · · · · · · · · · · ·	00	a Lianna				00   D		(1.0	D 141	
	5 m C O		29b. Signature and title of certifier	ulu	ex 1	10	1	c. License					-		Day, Year)	
)	(00)		Jule 0	0	0		1	(ピン	-00	0		MAR	CH (	0,2	800	
1			30. Name and address of person who													
		6 /	JACQUEUNE GARONZI			O NOR	v HT	OLF	E STR	LEET	BAL	timo	RE, M	ARY	LAND 2	1287
		te	31. Date filed (Month, Day, Year)	_ 32. H	egistrar's Signa	ature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Richard Norman Carson, Sr. 10:51 P. M 2008 March 6. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1X M 2 □ F **Funeral** Months Days Hours Min. 79 235-38-1970 20,1929 Wilder. Feb. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location t of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No MD Montgomery College Park Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 9719 Wichita Avenue 20740 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No White 3altimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nina Clara Dillon Beverley Vance Carson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9719 Wichita Ave., College Park, MD 20740 Beverly Kohn - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ō 03-12-2008 | Shepherdstown, WV Department of Important; If any Injury or once, Elmwood Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Eackles-Spencer & Norton Funeral Home
Harpers Ferry, WV 25425 21. Signature of Funeral Service Licenses M970 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical ICTIVE SLEEP APNOEA Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examiner Hospital or Attending Physlcian; The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 □ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has b autopsy performed certificate **≱**∏ No 1∐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 ☐ Pending investigation ours after death.
neral Director; Ai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical соmpletely (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 0 2008

31. Date filed (Month, Day, Year)

<ango

32. Registra

08-02064 Jesse Cody

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Medical Examiner** 0055 hrs Jesse Cody March 14, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 2007 Letitia Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 214-90-2537 Country) 1X M 2 F 31 1976 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Sussex Millville Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 30937 Oakwood Road 19970 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No f Yes, Give Year Yes 2X No specify: Specify: White Widowed Divorced ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-003 Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ant; If item 27 is marked o Be Talmadge Guy Cody Patsy Diana Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy D. Widmer/mother 30937 Oakwood Rd. Millville, DE 19970 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State portant: ry or othe 03/17/08 Chesapeake Crematory Beltsville, MD Donation 5 Other Specify: 22. Name and Address of Facility
Going Home Cremation Service anature of Euneral Service Licens P.O. Box 784 Beverly L. Heckrotte. P.A. Clarksvill MD the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical aHeroin Intoxication Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f per ME 4/4/08 amh ling physician a as the burial -X UNPENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>δ</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 2 No ✓ Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification:

Hospital or Attending Physician: Division of Vital After Director: hours after death. 24 hours a

Natural 2 Accident 3 Suicide

Homicide

Mary G. F

Pending Investigation 6 X Could not be

determined

28a. Date of Injury (Month, Day, Year) Fnd 3/13/08

Fnd at 11:55pm

Yes 2 X No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at residence

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2007 Letitia Ave, Balto., 1

March 14, 2008

29a. Certifier 1 Certifying Physician: o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Emminer: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

ss of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

32. Registrar's Signature 31. Date filed ( 8 2008

pple MD.

ORIGINAL

within 2 To the F

Medical

State

Registrar

Physic /Med		Decedent's Name (First, Middle, Las	State of Maryland / Dep m 24a per verb., g87		2. Date of Death		3. Time of Death
		Florenc	ce May Cartwright		March 6	2008	0624 <sup>M</sup>
Exam	iner	4e. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	th	4c. County of Death	
Funera		Caroline Nursing  5. Social Security Number 6. Se		Denton  If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Carolin 9. Birth	e place (State or Foreign
Funera Directo			□M 2□F 91 Yrs.	Months Days Hours Min		ar) Cou	ntry) nsylvania
P .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L				10d, Inside City Limits
Aaryla f sho	5						1 ☐ Yes 2√☐ No
289-	Director	Maryland Carolin  10e. Street and Number	ne Denton	10f. Zip Code	10g. (	Citizen of What Cou	ntry?
h with	0	24568 Mill Creek I	ane	21629	Unit	ted State	s of America
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event. It a Mudical Exprinat must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (! If Yes, specify Cuban, Mexican, Puel	Specify Yes or No-	14. Race - Amer Black, White	can Indian,
s afte	by Fu	1 Never Married 2 Married  3√√√Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 🗷 No Specify:	, , , ,	Specify:	
hour tural		15. Decedent's Ed	Year or Dates:	edent's Usual Occupation	16h	Kind of Business/Ir	casian
within 72 ene. than "na	Completed	(Specify only highest gra- Elementary/Secondary (0-12)	de completed) (Give life.	e kind of work done during most of wo DO NOT use retired)	orking	Turid or Dusinessari	iodotty
d with	Com	8		les Clerk		Bakery	
be filed Ital Hygi od other	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	en Sumame)	
2 should be and Mental is marked sumatic ev	2	Albert	Herlinger		nce Ottili $\epsilon$		
d2sh thanc 7 is n	10	19a. Informant's Name/Relationship (7) Florence M. North		ling Address (Street and Number or R			
Health tem 27		20a. Method of Disposition	20b. Place of Disp	8 Mill Creek Lane		Iary Land Location - City or T	21629 own, State
Pages nent of f int: If its		1 🖾 Burial 2 ☐ Cremation 3 ☐  3 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	ematory or other place) Cemetery 3/1	1/2008 E-4	4.4	Manager 1
그 튼튼증		21. Signature of Funeral Service Licent	300	2 Name and Address of Facility	1/2008 Fed	eralsbur,	, Maryland
Depared Important		* Faucifiles	Join	Moore Funeral Hom	e, P.A.	on. Marv	land 21629
		23a. Part 1. Enter the disease, or composhock, or heart failure. List only	plications that caused the death. Do not er	nter the mode of dying, such as cardia	c or respiratory arrest,	,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Alahein	iers Demen	Fi'a		Onset and Death
/Medica Examine		resulting in death)	Due to (or as a consequence of):				a
ZAUITINIC		Sequentially list conditions,	b. Due to (or as a consequence of):				
nsit	nln.	Sequentially list conditions, if any, leading to immediate cause. Enter Uncerty a Cause (Disease or injury	sala to (or as a consequence or).				
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death certificate be executed e attending physician and id for use as the burial-transit	Ical		d				
leath certifica attending ph I for use as th	Med	IF FEMALE:					
ath ce Itendi	Physician/Med	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
e e f	ysic	1 Yes 2 No	4 Pregnant at time of death 5 [ 9 Unknown	Other (specify)		17101111	Day Foul
무수	/ Ph	Part II. Other significant conditions co	ontributing to death but not resulting in the o	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	he cause of death?
that the led by the detache	ρ				1 ☐ Yes	20€No 3 □ Pro	bably 4 🗆 Unknown
quires that the death n signed by the atter ald be detached for i					24a. Was an	24b. Were aut	opsy findings available
v requires been sign should be						prior to or	impletion of cause of
law requires as been sigr 2 should be					autopsy performed	death?	
The law requires ate has been sign page 2 should be	e Completed	25. Was case referred to medical		26. Place of De	autopsy performed? 1 ☐ Yes 2 🛣 1 ath (Check only one)	death?	2 No
The law requires ate has been sign page 2 should be	To Be Completed	examiner? 1 Yes 2 Alo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	0.1	performed? 1 ☐ Yes 2 🔀 I	death?	2 No
Physician: The law requires this certificate has been sign al director, page 2 should be	To Be Completed	examiner? 1 Yes 2 No  27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)  28b. Time of Injury	ont 3 DOA Other: 4 Nursing to 28c. Injury at Work?	performed 1 ☐ Yes 2 🖾 I ath (Check only one)	death? 1 Yes 6 Other (Speci	2 No
Physician: The law requires this certificate has been sign al director, page 2 should be	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  18 Natiural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yeer)  28b. Time of Injury	ont 3 DOA Other: 4 Nursing to Vork?  M 1 Yes 2 No	performed:  1 Yes 2 1 1	death? 1 Yes  6 Other (Speci	2 No (y)
Physician: The law requires this certificate has been sign al director, page 2 should be	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1. Selection 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)  28b. Time of Injury	ont 3 DOA Other: 4 Nursing to Vork?  M 1 Yes 2 No	performed  1 Yes 2 X I  ath (Check only one)  Home 5 Residence	death? 1   Yes  6   Other (Specification)	2 No (y)
Physician: The law requires this certificate has been sign al director, page 2 should be	Certification: To Be Completed	examiner?  1 Yes 2 Ho  27. Manner of Death  1 Hatiural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Physical Certifying Physical Certifier	28a. Date of Injury (Month, Day Yeer)  28b. Place of Injury - At home, farm, st building, etc. (Specify)  28c. Place of Injury - At home, farm, st building, etc. (Specify)	ont 3 DOA Other: 4 Nursing to 28c. Injury at Work?  M 1 Yes 2 No treet, factory, office	performed:    Tyes 2	6 Other (Specification) occurred  and Number or Rurate)	2 No  (y)  al Route Number,
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or Attending Physician: The law requires itler death. Director: After this certificate has been sign in by the funeral director, page 2 should be	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1. Note: Accident investigation  3 Suicide 4 Homicide  29a. Certifier (Check only (Check only 1) Medical Exem	28a. Date of Injury (Month, Day Yeer)  28b. Place of Injury - At home, farm, st building, etc. (Specify)  28c. Place of Injury - At home, farm, st building, etc. (Specify)  28d. Place of Injury - At home, farm, st building, etc. (Specify)	ont 3 DOA Other: 4 Nursing to of 28c. Injury at Work?  M 1 Yes 2 No street, factory, office  th occurred at the time, date and place of the occurred at the occurred at the time, date and place of the occurred at the occurr	performed:    1	death? 1 Yes  6 Other (Special jury occurred)  and Number or Rurate)  (s) and manner as and place, and due to the place in the place in the place is the place in the place is the place is the place in the place is	2 No  No  All Route Number,  stated. o the cause(s)  Day, Year)
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Physician: The law requires this certificate has been sign al director, page 2 should be	Certification: To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 New Matural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who could not be determined	28a. Date of Injury (Month, Day Yeer)  28b. Place of Injury - At home, farm, st building, etc. (Specify)  28c. Place of Injury - At home, farm, st building, etc. (Specify)  28d. Place of Injury - At home, farm, st building, etc. (Specify)	ont 3 DOA Other: 4 Nursing to Street, factory, office  th occurred at the time, date and place the occurred at the occurred at the time, date and place the occurred at the occurred at the time, date and place the occurred at the oc	performed    1   Yes   2   1     ath (Check only one)    Home   5   Residence   28d. Describe how in    28f. Location (Street City or Town, Steet)   e, and due to the cause urred at the time, date at the time, date at the time.	death? 1 Yes  6 Other (Special jury occurred)  and Number or Rurate)  (s) and manner as and place, and due to the place in the place in the place is the place in the place is the place is the place in the place is	2 No  No  All Route Number,  stated. o the cause(s)  Day, Year)

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Registrar

MAR 2

2008

Physician  Mace and the control of t	(State or Foreign  DRK  Inside City Limits  I
March   Marc	SE'S (State or Foreign ) RK Inside City Limits Insi
Security of Death   Ac. Colly, Town, or Location of Death   Ac. Colly, Town, or Location of Death   PRINCE GEORGE'S HOSPITAL   CHEVERLY   PRINCE GEORGE   PRINCE GEORGE   S. Social Security, Number   S. Social Security	(State or Foreign  DRK  Inside City Limits  I
Funeral Director    Part   Par	(State or Foreign  DRK  Inside City Limits  I
Substitute   Sub	DRK  Inside City Limits
Usual Residence of Decedent  100. City, Town or Location  100. Its Use of The Part of the	nside City Limits  I Yes 2 No  Indian,  If Yes 2 No  Indian,  Indi
ERNEST A. DOW SR.  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 12922 BROADMORE ROAD, SILVER SPRING, MD 2090.  20a. Method of Disposition  1   Burial 2 Decremention 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Ligensee  22. Name and Address of Facility J. B. JENKINS FUNERAL HO. 7474 LANDOVER ROAD, LANDOVER, MD 20785  23a. Part In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if any leading to immediate cause (Final disease or condition resulting in death)  25c. Due to (or as a consequence of):	ndian,  de)  Adamond
ERNEST A. DOW SR.  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 12922 BROADMORE ROAD, SILVER SPRING, MD 2090.  20a. Method of Disposition  1   Burial 2 Decremention 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Ligensee  22. Name and Address of Facility J. B. JENKINS FUNERAL HO. 7474 LANDOVER ROAD, LANDOVER, MD 20785  23a. Part In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if any leading to immediate cause (Final disease or condition resulting in death)  25c. Due to (or as a consequence of):	ndian, Ty Tele) 14 State TD
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1   Burial 2   Cremation 3   Removal from State   RIVERDALE CREMATORY   MARCH 7, 2008 RIVERDALE, M	4 State
1   Burial 2   Cremation 3   Removal from State   RIVERDALE CREMATORY   MARCH 7, 2008 RIVERDALE, M	4 State
1   Burial 2   Cremation 3   Removal from State   RIVERDALE CREMATORY   MARCH 7, 2008 RIVERDALE, M	State ID
1   Burial 2   Cremation 3   Removal from State   RIVERDALE CREMATORY   MARCH 7, 2008 RIVERDALE, M	ÍD
Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate cause or intermediate cause (Final disease or conditions, if any, leading to immediate cause (Disease or injury that influted events resulting in death) Last  Due to (or as a consequence of):	
Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate cause or intermediate cause (Final disease or conditions, if any, leading to immediate cause (Disease or injury that influted events resulting in death) Last  Due to (or as a consequence of):	ME
Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  23a. Part fine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, such as cardiac or respiratory arrest, interest the mode of dying, suc	
Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)	proximate erval Between
resulting in death)  The sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	et and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	7
Due to (or as a consequence of):	moning
Due to (or as a consequence of):	19VS
	1
ficate be provided as the burn	
we de digital and the second and the	
23c. If yes, outcome pf pregnancy 23c. If yes, outcome pf pregnancy 1	y Year
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Part II. Other significant conditions contribution te death but not resulting in the underlying cause given in Part II.   23b. Did tobaccourse contribution te death but not resulting in the underlying cause given in Part II.   23b. Did tobaccourse contribution te death but not resulting in the underlying cause given in Part II.   23b. Did tobaccourse contribution te death but not resulting in the underlying cause given in Part II.   23b. Did tobaccourse contribution to the careful in the past 12 months?   1   Yes 2   Yes	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ca	ause of death?
So set is subject to s	4 □Unknown
24a. Was an autopsy for to complete autopsy for the complete autopsy fo	findings available
24a. Was an autopsy performed? In Yes 2 I No 1 Yes 2 I No 1 Yes 2	
25. Was case referred to medical examiner?	
Hospital: 1 Inpatient 2 DEF/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
28d. Describe how injury occurred  11 Natural 5 Pending (Month, Day Year)  12 Accident investigation  13 Pending (Month, Day Year)	
3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)  28f. Location (Street and Number or Rural Rot City or Town, State)	ute Number,
FEMALE:   23b. Was decedent pregnant   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)   Month   Day   1   Part II. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to death   1   Part III. Other significant conditions contributing to the death   1   Part III. Other significant conditions contributing to the death   1   Part III. Other significant   2   Part III. Other significant   2   Part III. Othe	
29a. Certifier (Check only (Ch	
29a. Certifier 1 29a. Certifier 29a.	
D162 73 3/5708	√Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	r≠Year)
LD REVATITY MUZTHE, 6130, Landover Ra, CA	Year)
29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  MAR 1 0 2008  And marrier stated.  29c. License number 23 29d. Date signed (Month, Day, Print)  29c. License number 3 3/5/08  29d. Date signed (Month, Day, Print)  32. Registrar's Signature  MAR 1 0 2008	Year)

DHMH 17 Rev 1/2001 DIL.

State Registrar

**ORIGINAL** 

			State of Maryland / I	-			lental Hygi	ene		
	-		Registrar  1. Decedent's Name (First, Middle, Last)	Cert	tificate of De	eatn	2. Date of Death	g. No. 2	108	3. Time of Death
	Physicia	an	Sandra R. Dorwart				Month	Day 10	Year 2008	12:27 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		narch		ty of Death	12:2/ [
			14845 Pilea Place		Hughesvil	.1e			Cha	rles
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) _ Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Coun	ace (State or Foreign try) ngton, DC
b	Director		217-82-7820 47  Usual Residence of Decedent	115.			July 3,	1960	wasnı	ngton, DC
	yland <b>now</b> at		10a. State 10b. County 10c. City, Tow	n or Loc	ation				10	Od. Inside City Limits
	e Mar a-fst	ctor	Maryland Charles Hug	ghes	ville					1 □Yes ŽŽNo
	or 28 be no	Directo	10e. Street and Number		10f. Zip Code	_	10	g. Citizen of		try?
	eath v	eral	14845 Pilea Place  11 Marital Status   12. Was Decedent Ever in U.S.	13 14	2063		or No.	U S	A ace - America	an Indian
	fter de r item iner r	Funeral	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No		as Decedent of Hispa Yes, specify Cuban, N	Mexican, Puerto	Rican, etc.)	Bla	ack, White,	etc.
2-0036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by	3 ☐ Widowed 4 ᡮ Divorced If Yes, Give Year or Dates:	1	∐Yes 2 No S	Specify:		Spec.	ity: Whi	te
2-0	72 h "natu dical	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decede (Give k	ent's Usual Occupation ind of work done during O NOT use retired)	n ng most of work	ing   1	6b. Kind of I	Business/Ind	lustry
2121	withir ene. than he Me	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		puter Spec			epartr	nent o	f the Navy
פ	il Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)		18	I. Mother's Name	e (First, Middle, M	laiden Surna	ıme)	
Maryland	uld be Wenta Irked Itic ev	To B	Frank Xavier Dorwart			Mary	Ann	1	Louden	
Jar.	2 sho l and I is ma rauma		· · · · · ·		Address (Street and			•		,
a) a`	1 and lealth sm 27 ther t				Queen Tre			SVIII6		
2 D	ages int of I t: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	ery, crem	atory or other place) d-Echols	3/14/	-		•	11, MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Brins:  21. Signature of Funeral Service Licensee /							
ñ	Dep Imp any onc		Jut Cleby B M00817	3	Tinsileid- 0195 Three	Notch	Rd., Cha	rlotte	e Hail	, MD 20622
ı	-		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	r the mode of dying, s	such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	- (	Lanc	en				Onset and Death
	/Medical Examiner		Due to (or as a consequence	of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):						
	cuted nd ransit	Examin	that initiated events							
8760,	icate be executed physician and s the burial-transit		resulting in death) Last  Due to (or as a consequence	of):						
287	physicate by the control of the cont	dical	d							
Box	death certifi e attending d for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy					23d. D	ate of delive	ery
-	at the death certifi I by the attending prached for use as	Physician/Me	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			N	<b>fonth</b>	Day Year
л О	nat the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	in the un	doduina seuso aivas i	n Port I	220 Did tob	2000 USO 00	ntributo to th	e cause of death?
ds,	The law requires that the tee has been signed by thoage 2 should be detache	d by	Fact II. Other significant containing to death but not resulting	n the an	denying cause given i	in anti-	1 □ Ye		3 ☐ Prob	1
Hecords,	w requ	letec			·		24a. Was ar	245	. Were auto	psy findings available
Ř	sician; The law certificate has l irector, page 2 s	Completed	1				autops: perform	ed?	prior to cor death?	npletion of cause of 2 □ No
Vital		Be C	25. Was case referred to medical		26	6. Place of Deat	1 Yes 2 h (Check only one		11162	2 10
	Physic this ce al direc	TOE					me 5 Reside	nce 6 🗀 O	ther (Specif	()
S O	ing Ph After th funeral		1 Natural 5 □ Pending (Month, Day Year)	Time of Injury	28c. Injury at Work? M 1 ☐ Yes	t s 2 □ No	28d. Describe ho	w injury occi	urred	
Division or	II or Attending Pase of death. I Director: After to in by the funera	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, for the determined determined between the country of the countr	arm, stre			28f. Location (Str	eet and Nun	nber or Rura	I Route Number,
5	spital or ours a er ours a er neral Dire filled n b	Certification:	4 ☐ Homicide determined building, etc. (Specify)				City or Town	, State)		
	e Hospital or Attend 24 hours a er death e Funeral Director.		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination a	je, death ind/or inv	occurred at the time, estigation, in my opini	date and place, ion, death occur	and due to the ca red at the time, da	use(s) and rate and place	manner as s e, and due to	tated. the cause(s)
	To the Hospital or Attending Physician: within 24 hours a fer death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. License nu	umber	29	d. Date sigr	ned (Month,	Day, Year)
	€ ≥ F 2		* KMa()Wx		240	-35	7	3-1	1-0	2
•	<b>X</b>		30. Name and address of person who completed cause of death (Item 23a)	(Type, F	Print)	Λ -	2 2			<u>.                                    </u>
	. U	1	31. Date filed (Month, Day, Year) 37 Registrar's Signature	01	110th	$\sim$ /	7 9	066	(6)	, i
	Sta Registr		MAR 1 2 2003	100						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death MARCH 2008 **Physician** 7:56 Am ROBIN MICHELLE EDELIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√ F 48 579-84-5616 Director WASHINGTON, DC 1960 JAN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 28a-f show 1 MYes 2 □ No Director PRINCE GEORGE'S HYATTSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7110 EAST FOREST ROAD 20785 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married BLACK 1 ☐ Yes 2 🖁 No Baltimore, Maryland 21215-0036 Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) PRIVATE HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT EDELIN JEAN TAYLOR ပ 19a. Informant's Name/Relationship (Type. Print)
CHERIE SMITH/SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip, Code) 18 BOOTH COURT STAFFORD, VIRGINIA 22554 Date 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3/8/2008 SUITLAND, MARYLAND LINCOLN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B.JENKINS FUNERAL HOME nak 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** remoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 00A 1 🗋 Inpatient 2 ER/Outpatient ၉ 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Puhner 1328 Southen aven Sunte 310 Washington 31. Date filed (Month, Day, Year) 32. Registrar's Signat State 2008

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Registrar

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	Funeral Director		5. Social Security Number 6. Sec. 577–28–6151  Usual Residence of Decedent	7. Age	e (In yrs. last 86	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Feb. 26	y, Year) 192	2	9. Birthp Coun Washi	lace (State ( try) ington,	or Foreign DC
	Maryland -f ehow	tor	10a. State 10b. County  Maryland Prince Geo	rge's	10c. City, T	own or Lo	cation						_	11	0d. Inside C	ity Limits
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036	is 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23a or 28a-1 show other traumatic event, if a Medical Exaction at must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  ★★Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 4 6 If Yes, Give Year or Dates:			Vas Deced Yes, spec □Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	-		e - Americ k, White, o		
Baltimore, Maryland 21215-0036	od within 72 hogiene. giene. sr then "netui	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12			6a. Deced (Give i life. L	ent's Usua kind of work O NOT us Iomemal	l Occupa k done d e retired) KCT	ition uring most	of workir	ng	16b. Ki		siness/Ind	•	
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more	permit. Pages 1 en Department of Heal Important: if Item 2 eny injury or othsr 2006.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place ceme Ft. L	e of Dispose etery, crem incolr					, 2008			City or To		
Balti	permit. Departn imports eny inju		21. Signature of Funeral Service Ligense	90	S	22.	Name and	d Addres	s of Facility	Geor	ge P. Ka Hill, N	alas l	Funera		ne PA	
	Physician		23a. Part 1 Enter the disease, or compli shows, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused ne cause on each lin SEPS	е.	o not ente	r the mode	of dying	, such as o	cardiac or	respiratory ar	rest,			Approximat Interval Bet Onset and	ween
H	/Medical Examiner		resulting in death)	Due to (or as a	iconsequence IPLE (		FAIL	URE							*	
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O. Box 6	requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the g □ Unknown	2 Fetal dea	ath 3□	Ectopic pre Other (spe					2	23d. Date Mon	of deliver	*	/ear
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DIVISION OF	i or Attending Physician: after death. Director: After this certifica i in by the funeral director, i	ertification: T	27. Manner of Death  1XXNaturat 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day		D. Time of Injury		c. Injury Work		2	8d. Describe h				/	
	ital or Att urs after de rsi Direct lled in by t	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	. (Specify)						Bf. Location (S City or Tow	n, State)	)			ber,
	To the Hospital or At within 24 hours after or To the Funers! Direct completely filled in by	Medical	29a. Certifier Check only 2 Medical Examin	ician: To the best of er: On the basis of and manner stat	examination a	dge, death and/or inve	estigation, i	in my opi	nion, death	place, ar	d at the time, o	late and	place, a	nd due to	the cause(s	)
•			29b. Signature and title of certifier	0,	-		D	License	PO C	7		_	-	(Month, E 2008		
			30. Name an address of person who co Raman R. Tuli M	D 3503 P	erry S	treet		Mt.	Raini	er.	Marylar	nd :	2071;	2		
	Sta Registra	_	MAR 0 7 2008	32. Registra	r's Signature	e										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Anita Louise Grooms 3/3/2008 5:30pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F 577541<u>396</u> Director 68 10/1/1939 Wash. D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. Cify, Town or Location 10a State 10b County 10d. Inside City Limits show r 28a-f show notified at Yes 2 No D.C. Director Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be r 5010 Southern Ave. S.E. 20019 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☑ Divorced "natural". the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Manager Private other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked of Louise Beatrice Ford Ernest Liverpool 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other tra Linda Murphy/ Daughter 116 Onondago Drive. Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 3/15/2008 Suitland, Maryland Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. M01085 5538 Marlboro Pike Forestville, Md. 20747 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transil Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 328 SOUTHERN AVE SE-DC Date filed (Month, Day, Year)
MAR 0 7 2008 MD 32. Registrar's Sign

DHMH 17 Rev 1/2001

State Registrar

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•	Examin	er	456 Bafford Road	.,	Lusby			Calvert		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐XM 2 ☐ F	. Age (In yrs. last birthda 47 <sup>Yrs</sup>	Manufille Deve	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) October 2	Year)	9. Birthp Coun Maryla	
	h with the Maryland 23a or 28a-f show st be notified at	al Director	Usual Residence of Decedent	10c. City, Town or Lusby	Location  10f. Zip Code	20657	1	0g. Citizen of W		Od. Inside City Limits 1 ☐ Yes 2 ☒ No try?
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0,00,	Physician /Medical Examiner step prize pri	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	r as a consequence of):	sme (and					Onset and Death
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DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.	ation: To	27. Manner of Death 28a. Date of	·	y Wor	y at	ome 5 PResidence 28d. Describe he			y)
DIVIS	al or Atte s after dex al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place c buildin	of injury - At home, farm, g, etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow		er or Rura	l Route Number,
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	To the within To the comp	Me	29b. Signature and title of certifier		29c. Licens	e number 56024	2	29d. Date signed		
)			, and	,		76074		March	10 6	U)3
			30. Name and address of person who completed cause Kenneth L. ALL. + 110	Hospital Road	Sure 110	Prince F	redense	HD ZI	1678	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2008 March 1:30 P M Francis Marion Goode /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel 6523 Wilson Road Friendship If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 9 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months 1**∑** M 2□ F 1914 Maryland 93 Director 578-05-5179 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 → No Director MD Anne Arundel Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6523 Wilson Road 20758 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 🎇 No Specify 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mechanic/salesman automotive parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Perry Goode Emily George ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6523 Wilson Road, Friendship, MD Jacqueline H. Lauer, niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 03-04-2008 Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** teriosc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of performe death? 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Nesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 Z No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) pres 32. Registra Signature 31. Date filed (Month, Day, State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 17:20 PM Zilphia Toni Gee February 29. 2008 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 1 □ M 2 X F Months Days Hours 463-66-9519 66 Dec 11, 1941 Texas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Maryland Prince George's Greenbelt 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 203 Lakeside Drive #103 20770 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**No 1 Never Married 2 Married 1 ☐ Yes 🎾 No Specify Specify 3 ☐ Widowed 4 X Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher years Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Powell Lloyd Georgiana Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mamie L. Smith - Sister 9045 Campina Dr. #A La Mesa CA 91942 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee's Crematory 3/10/08 Clinton, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part1. Enter the diseas shock on heart failure. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Pneumonia Due to (or as a consequence of) Bacteremia Due to (or as a consequence of): Congestive Heart Failure Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown

Physician /Medical Examiner

the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

or Attending

Hospital

within 24

**Physician** 

/Medical

Examiner

10a, State

**Funeral** 

Director

iral", or items 23a or 28a-f show Examiner must be notified at

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Pages 1 and 2 should I

Health a

Department of Health Important: If item 27 any injury or other tr

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Baltimore, Maryland 21215-0036

Director

Funeral

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Examine Physician/Medical þ

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Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 XUnknowr

> 24a. Was an autopsy performed? 1 Yes 2 X No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No

2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number 20056063

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K-Nagi, M.D. 1500 Forest Glen Road Silver Spring, MD 20910

State Registrar

filled in by

Medical

31. Date filed (Month, Day, Year)
MAR 0 6 2008 MAR 06



and manner stated.

MD

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To the Hospital or Attending Physician: The law requires that the death certification within 24 hours aller death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		ng Physician: To the Examiner: On the												(s)
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	-	30. Name and address of person	who completed car	use of death (II	tem 23a) (Type.	Print)					l ria	L CII I	-, -	300	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O'S Danny R. Gates or Location of Death 4c. County of Death 4a. FacilityName (If not institution, give street and nun Micomico 0 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 6/3/1943) 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday) Months 1**X** M 2□ F 498-46-9160 64 KS Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Chester West Chester 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 881 Frank Rd. 19380 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Plummer Gates Margaret Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 881 Frank Rd., West Chester. PA 19380 Janis Gates / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/10/2008 Frankford, DE 4 □ Donation 5 □ Other (Specify) of Funeral Service 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC RSOPHAGRAL CARCINOMA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence off Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed? res 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2[X] No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

death certificate be executed and physician are the buriat-t P.O. Box 68760, as signed by the attending particular by the detached for use as Division or Vital Records, page 2 s has certificate To the Funeral Director: After this completely filled in by the funeral dir or Attending death. after To the Hospital within 24 hours

**Physician** 

/Medical

Examiner

Director

Funeral

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Certification:

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**Funeral** 

Director

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r than "natural", or items 23a or the Medical Examiner must be

Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, <u>the once.</u>

**Physician** 

/Medical

Examiner

Pages 1 and 2 should

after

Baltimore, Maryland 21215-0036

RA 10+1

State Registrar

29a. Certifier

(Check only one)

GHUNAM WARLS 31. Date filed (Month, Day, Year) MAR 1 0 2008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL HOSPICE

2005 8410

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

03-02-02

PUBOX 1733 SALISBURY UND 21802

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** March 3, 9:25 P M Robert John Ghetti 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7020 Channel Village Ct., #201 Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 019-34-5723 7/13/1944 **Director** Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if them 27 is marked other than "nature!" ------- any injury or other tra-----------10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 24 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7020 Channel Village Ct., #201 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Energy Deputy Assistant Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Samuel Ghetti Marie Theresa Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet M. Ghetti/ Wife 13145 Scarlet Oak Dr., Darnestown, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory Edgewater, MD 3/6/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home Mobert 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Altulioschotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in ilitated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Division or Vital Records, P.O. Box 68760,

41479

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March

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year) MAR 0 6 2008

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			1- For State Registrar	•	tificate c			eg. No. 200	8 1921
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Copy			4a. Facility Name (if not institution, given 5821 Marlboro Pike #201	e street and number)		4b. City, Town, or Location of Deal District Heights		4c. County of Deat Prince Georg	
	Funeral Director		5. Social Security Number 6. Se 577-90-3666 1	7. Age (In yrs. I	ast birthday) Yr	If Under 1 Year If Under 24Hr Months Days Hours Mi			rthplace (State of Geign
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	he Maryland or 28a-f sh	Director	10e. Street and Number 3826 E. Capi	tal Street N		10f. Zip Code 20019	1	0g. Citizen of What Cou	
13	imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland  men of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 XNever Married 2 Married	12. Was Decedent Ever in U Armed Forces?  1 Yes 2 X No If Yes, Give Year	.S. 13. W	l'as Decedent of Hispanic Origin? ( \$ Yes, specify Cuban, Mexican, Puert  Yes 2 X No specify:		White, etc.	rican Indian, Black,
11	5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	ompleted by	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	Or Dates: ally highest grade completed) College (1-4 or 5+)	during r	ent's Usual Occupation (Give kind of most of working life. DO NOT use re Driver	tired)	16b. Kind of Business Metro	/Industry
	21215-0 uld be filed w Mental Hygic marked othe	BeC	17. Father's Name (First, Middle, Last) Henry Elv	in Archie		18.Mother's Nam Doris	S. Ha	Maiden Surname) ney	
	MD 21 d 2 should 1 Ith and Mer n 27 is mar numatic ev	T <sub>0</sub>	19a. Informant's Name/Relationship (T Doris Jones/mc	ther	3826	ng Address (Street and Number or E. Capital S		Wash, DC	20019
	Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m Injury or other traumatic.		Donation/5 Utner Specify.	Removal from State Ha:	crematory or c rmony		Date 6 / 0 8	20c. Location - City of Landover	
	Balt permit, Depart Impor Injury		21. Signature of Funeral Syrvice 103	enry	В	Name and Address of Facility  K Henry Funera			
Í	Physician /Medical xaminer		4.4		ardiovas		or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
		aminer	cause. Enter Underlying Cause	Due to (or as a consequence o	of):				
	cuted ind transit	ш	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of					
	D, be execute sician and vurial - tran	dica	X UNPENDED	AMENDED 23a,27 per	r ME g87	7 3/25/08 amh			
	tal Records, P.O. Box 68760, cinn: The law requires that the death certificate be execut certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - tran	ıysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg  1 Live birth  4 Pregnant at time of de	2 F	Tetal death 3 Ectopic pregu	nancy	23d. Date of delive Month	rry Day Year
	P.O. es that the igned by the detache	by Phy	Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying cause given in Part I.		obacco use contribute t	
	of Vital Records, ng Physician: The law requir offer this certificate has been someral director, page 2 should the control of	Completed			-				
		o Be C	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	ER/Outpatier	26.Place of Death (Chec	k only one)	Residence 6 ✓ Oth	
	nding Phy th.: After the		1 V Yes 2 No  27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of			how injury occurred	
	Division of Vital I  24 hours after death.  2 feueral Director: After this certificately filled in by the funeral director,	Certification:	2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. Place of Injury - At h	ome, farm, str	eet, factory, office building, etc.	28f. Location ( or Town, \$		Rural Route Number, City
	e Host 124 ho e Fune etely f	sal C	20a Certifier	an: To the best of my knowled	ge, death occ	urred at the time, date and place, ar	d due to the cau	se(s) and manner as st	ated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 27, 2008

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month, Day, Year) gistrar MAR 2 1 2008 Registrar

29b. Signature and title of certifier

OCME

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 220 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Ctr. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5.224ial 36cugi9777 mber 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 🗆 M <del>-35-8977</del> 84 Yrs. **Director** August 16, 1923 Viroinia Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at Southampton VA Ivor 1X Yes 2 □ No be notified Director 10e. Street and Number Froctors 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with , or items 23a or 8037 Prectras Bridge Rd U.S. 23866 7 Is marked other than "natural", or items 238 traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes **②**【☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐**X**No Specify: <u>ک</u> 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 Is marked other than any injury or other traumatic event, the 1 once. Dietician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Davis Bessie Clary ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aravia Holloman - Daughter 1511 Pinelake Lane, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 3-15-08 C. Warren Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Ivor, Virginia 22. Name and Address of Facility Bornette & Assoc. Fureral Hore Inc. 21. Signature of Funeral Service Licensee 2504 28th St., N.E., WDC 20018 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** likanon /Medical Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed Due to (or as a consequence of): burial-P.O. Box 68760, physician Physician/Medical the attending p as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕏 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 ☐ Unknowi signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 1 TYes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No page 2 certificate 25. Was case referred to medica examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Lo 1 Unpatient 2 ER/Outpatient 3□ D0A this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending Injury the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 1438 Name and address of person in completed cause of death (Item 23a) (Type, Print) me FFENSE 445 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 🗸 🔱 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician 01, 2008 1349 YVONNE L. March HENRY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY HOSPITAL SILVER SPRING HOLY CROSS If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ⋤ F Yrs. Director 250945147 57 12/2/1950 Charleston, S.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y⊒Yes 2 No Directo Maryland Prince George's Clinton 10f. Zip Code 10g, Citizen of What Country? Funeral 9321 Linhurst Drive 20735 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Completed by Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Program Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 erov Butler Shirley Rell Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evol V. Henry / Husband 9321 Linhurst Dr. Clinton, Md. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection 3/8/2006
22. Name and Address of Facility Pope Funeral Homes, P.A. 2074 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service disensee MO1089 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>5538 Marlboro Pike Forestville. Md. 20747</u> Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner b. Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans c. Cellulitis Due to (or as a consequence of): P.O. Box 68760. Physician/Medical d. Anemia attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🖾 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performed?

1 Yes 2 XNo or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAR 0 7 2008

1500 Forest Glen Road Silver Spring, Md. 20910 Kshama Garg M D 32. Registrar's S

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

D60826

3/4/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2**,** 2008 Month **Physician** Barbara Huff 2342 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) January 24, 1944 Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 🖫 578-52-4850 Director 64 D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. arist: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits Hyattsville 1XTYes 2 No MD P.G. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 U.S. 5034 38th Avenue 20782 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 X No f Yes, Give 1 Never Married 2 Married African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecomunications Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Wright Isabell Mathews 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5034 38th Avenue, Hyattsville, MD 20782 John Huff-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or c Nation | 2 □ Cremation | 3 □ Removal from State 3-11-08 Glenwood Cemetery Washington, D.C. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Hone Inc. 21. Signature of Funeral Service Licensee 2504 28th Street, N.E., WDC 20018 P. F. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such a prardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown Completed

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, signed by the a d be detached f page 2 should be

the Hospital or Attending Physician: After this after death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**€** No 1 TYes 2 ☐ ER/Outpatient 3□ DOA Inpatient Date of Injury (Month, Day Year) 27. Manufer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Check only

Medical

Be

Certification: To

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (It in 23a) (Type, Print)

2008

29c. License number

29d. Date signed (Month Day, Year)

31. Date filed (Month, Day, Year

MAR 0 7

32. Registrar's Signat

within 24

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		1 - State Registrar			C	ertificate of L	Death	Reg	3. No. 0 0 0 0	00010	
Physici	ian	1. Decedent's Name (First, Middle						Date of Death     Month	Day Coo Year	3. Time of Death	
Physici /Medic		Margaret	Virginia H	oover				March 5	, 2008	5:20 AM	
Examir	ner	4a. Facility Name (If not institutio		)		4b. City, Town, or	Location of Death		4c. County of Deat	h	
		4185 Fox Den 1					ingtown		Calve	ert	
Funeral Director		5. Social Security Number  579–12–5836  Usual Residence of Decedent	6. Sex 7. A(	ge ( <i>In yr</i> s. <i>I</i> 8 <b>7</b>	ast birthda Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) Sep 27,	rear) Co	hplace (State or Foreign untry) rginia	
and w		10a. State 10b. County	,	10c. City	, Town or	Location				10d. Inside City Limits	
Mary f sho led a	0	MD (	Calvert	H	untii	ngtown				1 ∐Yes 2 XiNo	
the 128a-	Director	10e. Street and Number				10f. Zip Code		100	. Citizen of What Co	untry?	
Sa or t be		4185 Fox Den	Lano			208	330	'*	USA	-	
mus 2	Funeral	11. Marital Status	12. Was Decedent		3. 1	Was Decedent of Hi     If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Inportant: If fiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Vas Giva			If Yes, specify Cuba 1 ☐ Yes 2 【XNo	n', Mexican', Puèrto Specify:	Rićan, etc.)	Black, White	e, etc. <b>hit</b> e	
in 72 ho n "natur Aedical J	Completed	(Specify only highe	nt's Education est grade completed)		(G	cedent's Usual Occupa ive kind of work done of e. DO NOT use retired	luring most of work	ing 16	6b. Kind of Business/	Industry	
i with jiene r thai	E	Elementary/Secondary (0-12)  10	College (1-4or	5+)	S	ales Associ	iate		Retail S	Sales	
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uld be Aenta Aenta rked tic e	To B	Joseph		Wh	ite		Alic	e	H	louse	
shous and A		19a. Informant's Name/Relations	ship (Type. Print)		19b. Ma	ailing Address (Street a	and Number or Rur	al Route Number,	City or Town, State, 2	Zip Code)	
and 2		Linda Hickey (	daughter)		418	5 Fox Den I	Lane Hun	tingtown	MD 2063	9	
ages 1 and to the control of the con		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation		CE	emetery, c	sposition (Name of rematory or other place	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	Oc. Location - City or		
it. Partme		4 □ Donation 5 □ Other (S		Sou	merr	n Mem Grdns 22. Name and Addres	: 20		Dunkirk,		
Depa Impo any I			J. Golf			8125 South	40		l Home Cal d. Owings	•	
A ST ST ST ST		23a. Part1. Enter the disease, or	r complications that cause	d the death	. Do not	The state of the s				Approximate	
Physician		Immediate Cause (Final	t only one cause on each l	ine.		1		- '		Interval Between Onset and Death	
/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Chronic Obstructive Pulmonary Discase  Due to (or as a consequence of):									
Examiner	Ш		Due to tor as	a consequ	ence on,	e due top	المحمدان	Dante.	120 t +	-000	
	ē	Sequentially list conditions, if any, leading to immediate	b. Tue to (or as	a consequ	ence of):	E CANCE 18 Jan		Jan 10031	on erec in		
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rcate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):									
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g ph)	Medical										
requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal	death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deli Month	ivery Day Year	
man ned by deta		Part II. Other significant condition	ons contributing to death t	out not resu	ting in the	underlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
w requires that is been signed to should be detailed	ed by							17 Yes	2  No 3  Pr	obably 4 □Unknown	
Ine law ate has b page 2 sl	Completed							24a. Was an autopsy performe 1□ Yes 2	prior to c	topsy findings available completion of cause of	
artific ctor,	Be C	25. Was case referred to medica examiner?					26. Place of Deat	(Check only one)			
direction of the contraction of	70	1 ☐ Yes 2☐ No	Hospital: 1 ☐ Inpatio	ent 2□E	R/Outpat	ient 3□ DOA Othe	r: 4 Nursing Ho	me 5 Residen	ce 6 ☐Other (Spec	cify)	
fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da		28b. Time Injur		at ?	28d. Describe how	injury occurred		
or: Al	atic	2 ☐ Accident investig	gation			' I _	res 2 □ No				
after de Direct	Certification:	3 Suicide 6 Could determ	sined   28e. Place of Inj	iury - At hor tc. <i>(Specify,</i>	ne, farm,	street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,	
one nospiral or Attending Priysican: within 24 hours after death.  To the Euhoursal Director: After this certifica completely filled in by the funeral director,	edical Co	29a. Certifier (Check only one)  Certifyir 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examinati	/ledge, de on and/or	eath occurred at the tim investigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)	
Withir To th	Me	29b. Signature and title of certifie	r 0	A		29c. License	number		I. Date signed (Monti	- /	
		) Do	wy long	be M	0	D476	310	1	land 5,	2008	
3		30. Name and address of person David J. Tar				e, Print) Road Pri	nce Fred	erick. M	20678		
Sta Registr		31. Date filed (Month, Day, Year)		1.0:	4	West .					

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 **Physician** Haller Linda Judy 4:00A M MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner (a) 1 3e arfor orien iverside cam 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Days Months Hours 62 Director 217-46-2553 6/10/1945 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 Nes 2 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Roosevelt Ave. Apt. H-1 21001 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Completed by Specify: 3 Widowed 4 □ Divorced White "natura!" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown P Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Terry D. Hanratty (Son) 925 Carsin Run Road Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 3/19/08 Baltimore, MD 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 1 Tyes Physician: funeral director, 25. Was case referred edical Be 26. Place of Death (Check only one) examiner' 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Many er of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 1 Natural (Month, Day Year) 5 Pending death. investigation 1 ☐ Yes 2 🗆 No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) 30. Name and address of person who com

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Faye Isemann 10, 2008 March 8:40 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 22680 Cedar Lane Court Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛚 F Director 68 02/18/1940 579-50-3726 Washington, DC Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a, State 10b. County 10d. inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22680 Cedar Lane Court 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 Widowed 4 Noivorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Compositor Newspaper permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lummie Malcolm Eugenia Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loraine Elder/ Personal Rep. 25070 Gallant Man Drive, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Charles Memorial Gdn. 3-14-2008 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final METASTATIC Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ ARTERY 1 ☐ Yes 2 ☐ No 1 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

Hospital or Attending Physician: 24 hours after death. 24 hours a To the within 2

DHME

	12A) GINIA		- 6966
State Registrar	31. Date filed (Month Year)	2 2008	32. Figistrar
17 Rev 1/2001			

29a. Certifier

(Check only one)

29b. Signature and title of certifier

SMAM ASSOCIATES s Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

3-10-08

HOLLYWOOD and

			1 For State	State of M	larylar						470- 470-	0.0	00211
1 - State Registrar Certification   1. Decedent's Name (First, Middle, Last)							rtificate of Death  Reg. No. 2 0 8 0 9 2 1					3. Time of Death	
	Physici /Medi		Margaret	Basala	Jol	hnson				Month March	Day	Year	1:46 p M
	Examir		4a. Facility Name (If not institution				4b. City, Town,	or Location	of Death	naren .	<del>-</del>	y of Death	1.40 p
		e l	12801 Meadowb					ldorf			Cha	arles	
В	Funeral		5. Social Security Number	6. Sex 7. A		last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day,	Year)	Cour	lace (State or Foreign try)
J.	Director		189-18-7725 Usual Residence of Decedent		84					June 29	,1923	Penns	ylvania
	ryland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
	e Ma Ba-f s	Director	Maryland Cha	arles		Hughe	sville_						1 □Yes 24□ No
	vith th		10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Coun	try?
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10	r Item	Fun	1 ☐ Never Married 2 ☐ Marr.	Armed Forces	?	.5.	Was Decedent of f Yes, specify Cul	oan, Mexica	n, Puerto F	Rican, etc.)		ck, White,	
036	ours a ral", o Exan	l by	3₺Widowed 4 Divorced	if Yes, Give Year or Dates:			I□Yes 2√√ No	Specify:			Specii	y: Wh	ite
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<b>d</b> 2	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle,	Last)			Homemake		er's Name	(First, Middle, M		n Hom	е
lan,	uld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atic event, the Medical Examiner must be notified at	To B	Alik	Basala				E1:	lona		Jaruck	o	
lary	2 short and 1 short short short and 1 short shor		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailin	g Address (Stree	t and Numbe	er or Rural	Route Number	City or Town	, State, Zip	Code)
≥,	and fealth m 27 her tr		Evonne Kerriga	n/Daughter_		1777	0 Maxwel	1 Hal					
Jore	ages 1 nt of H : If ite		20a. Method of Disposition 1X Burial 2 □ Cremation		, I		sition (Name of natory or other pla	· i			20c. Location	- City or To	wn, State
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (S <sub>i</sub> 21. Signature of Fune <sub>M</sub> al Service		Ar]		Nationa		4/3/2				Virginia
ä	Imp any any		1)2 to	Chol De	1800	7 37	insfield 195 Thre	-Echo e Not	ls Fu	neral H	lome, P	Hall,	MD 20622
e	a . Si		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the deatl								Approximate Interval Between
	Physician	İ	immediate Cause (Final disease or condition	a. Demen									Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):							
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9 X	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	nf nrenna	ancv							
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 Feta	ıl death 3□	Ectopic pregnand Other (specify)_	У				ite of delive onth	ry Day Year
Ö.	at the de by the tached	hysi	1 ☐ Yes 2√2 No 9 ☐ Unknown	9□Unknown									
S, D	es thai	by P	Part II. Other significant condition	ns contributing to death t	out not resu	ulting in the un	derlying cause gi	ven in Part i.		23e. Did tob	acco use conf	tribute to th	e cause of death?
ord	w requires been sign should be									1 ☐ Ye	s 2□No	3 Proba	ably 💹 Unknown
Vital Records,	e 2 sl	Completed								24a. Was an		Were autop	sy findings available apletion of cause of
a										perform	red?	death?	2 No
	Physician; rthis certificaral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital: 1   Inpati	ont 0 🗆	ER/Outpatient	2□ DOA Oth			Check only one			Assisted
	g Phys er this eral dii	F 1	27. Manner of Death	28a. Date of Inju	ury	28b. Time of	28c. Inju	4 □ Nu		e 5 Reside			Living
Š	Attending I r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	y rear)	Injury		rk? ∣Yes 2∐i	No				
DIVISION	or Atten after death Director; in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At ho tc. (Specify	ome, farm, stre	et, factory, office		28	f. Location (Str. City or Town,		er or Rural	Route Number,
_	e Hospital or At 124 hours after of E Funeral Direct letely filled in by		29a. Certifier 115 CertifyInd	Physician: To the best	of my length	ulodeo desello		1.1	1				
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examinat	tion and/or inv	estigation, in my	opinion, dea	th occurre	d at the time, da	use(s) and ma ite and place,	anner as sta and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	se number		29	d. Date signe	d (Month, L	Day, Year)
			> >> > > > > > > > > > > > > > > > > >	MD			D	50290	)		3-1	11-00	6
			30. Name and address of person v										
	Sta	e	Dhiren Shah, 31. Date filed (Month, Day, Year)	MD 110 32. Registr	HOSP ar's Signal	ital Ro	d., Prin	ce Fre	ederi	ck, MD	20678_		
	Registra	ar	31. Date filed (Month, Day, Year)	Charles X	Appa	ME.							

Division or Vital Records, P.O. Box 68760.

Hee) ulcus Vasc	wlar Disease.	Perpheral	24a. Was an autopsy performed? 1□ Yes 2 240	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of thath  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how Injury occurred						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, of building, etc. (Specify)	office 28	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 Certifying Ph	ny sician: To the best of my knowledge, death occurred at niner: On the basis of examination and/or investigation, in	t the time, date and place, ar n my opinion, death occurred	nd due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)					

29c. License number

Talcoma

7420200

29d. Date signed (Month, Day, Year)

OFO JI

NARCH 4, 2008

MDFACP

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier.

MAR 0 6 2008

Hampshere Avenue 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 D = 01 L C

Medical

State Registrar DR. KAREN

31. Date filed (Month, D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIRSCH

4 4940, EASTERN AVENUE BALTIMORE, MD

RES-000

MARCH

			1 - For State Registrar	State of Ma	ırylan	d / Depa	artment of F	lealth and			e 2008	09218	}
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date o		ay Year	3. Time of Death	
1	/Medi		Ann Elizabeth			-			2/29	/200	8	5:25 pm	
	Examir	ner	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or			40	. County of Dea	th	
			Fort. Washingto			last birthday)	Fort Was	shingt   If Under 24 F	ON Irs. 8. Date o			George's	_
п	Funeral Director			□M 200 F 6.5		Yrs.	Months Days		in. (Month	, Day, Year 1938		thplace (State or Foreign	7
	ס		Usual Residence of Decedent						0/19	/ 1930	Was	sh. D.C.	_
	aryiar	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	he M	Director	D.C.		Was	hingt						Yes 2 □ No	
	with t	ā	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?	
	leath	Funerai	800 Southern Av	12. Was Decedent E		008	20032	Isnanio Origin?	(Specify Vas o	Unit	ed State	encan Indian,	_
က	or iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔁 N		ff	Vas Decedent of H Yes, specify Cuba		erto Rican, etc.	)	Black, Whi	te, etc.	
9	hours after death with the Maryland turel', or Items 23e or 28a-f show al Examiner must be notified at	t by	3X Widowed 4 □ Divorced	ff Yes, Give Year or Dates:		1	☐ Yes 21 No	Specify:			Specify: Bl	ack	
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Maryland 21215-0036	shoul nd Ma rhari urnati	T <sub>0</sub>	Arthur Thorogoo	D.C		19b. Mailin	g Address (Street a		<u>de Can</u> Rural Route Nu			Zip Code)	_
	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		Ataro Morris/ S	Son								C. 20032	
Baltimore,	iges 1 and of Head		20a. Method of Disposition 1 ⊠ Buriaf 2 ☐ Cremation 3 ☐		20b. P	face of Dispos	sition (Name of atory or other plac		Date		ocation - City or		
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3alî	permit. Pag Department Important: eny injury once.		21. Signature of Funeral Service Licen	699		22.	Name and Addres	s of Facility	pe Fui	neral	Homes	P.A.	
_	g. □ = 0		7 8/1 a. Ba	MOL DON	085	55	38 Marl	boro E	Pike Fo	prest	ville,	_Md. 2074	. 7
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pfications that caused one cause on each line	the death e. •	. Do not ente	r the mode of dyin	g, such as card	iac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequ	uence of):	exa	6	a cc	*\	-	3	
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ő	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a	consequ	ience of):							
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dicai		d									
Box 6	leath certific attending pl	Physician/Med	IF FEMALE:	23c. If yes, outcome of	4								
B	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	Fetal	death 3 1	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year	
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Records,	has be	piet							24a. V	Vas an utopsy	24b. Were au	itopsy findings available completion of cause of	
<u> </u>	The ate h page	Completed							p 1□Ye	erformed2	death?	2□ No	
Division of Vital	hysician: The la	Be	25. Was case referred to medical examiner?	Hamital.					eath (Check or				
o	Phys this ral dir	2	1 ☐ Yes 2 Ø No  27. Manner of Death	Hospital: 10 Inpatien 28a. Date of Injury		R/Outpatient		4 🗀 IAUI SII IĞ	7		6 ☐Other (Spe	cify)	_
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/ISI	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injur	y - At ho	me, farm, stre		2 110	28f. Locatio	n (Street ar	nd Number or Ri	ıral Route Number.	-
á	2 2 2 2	Certification;	4  Homicide determined	building, etc.	(Specity)	)	- · · · · · · · · · · · · · · · · · · ·			Town, State			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai (		ysician: To the best of liner: On the basis of e	my knov	vledge, death	occurred at the time	e, date and pla	ce, and due to	the cause(s	) and manner as	stated.	-
	o the ithin 2 o the omplet	Med	one) 29b. Signature and title of certifier	and manner state	∍d.		29c. License				te signed (Mont		_
)	To with		DA TI AS	alala a		Me		4604	46	2.30. Da		2008	
2	_	+	30. Name and address of person who o	completed cause of de-	ath (Item	23a) (Type B		,	, 10	5	10,-	7778	_
			Amir Mirza- Alikha				ngston R	d Fort	machi-	orton	MA 20	7 /. /.	
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	Registra	ır	MAR 0 7 2008	Kludge > 15	14	me							

		1 - For State Registrar	State o	f Marylan		artment rtificate			and Me		giene Reg. No.	/ 1111	8	09219
Physicia /Medic		Decedent's Name (First, Middle,     Lillian Cleon L	ıcas			r · · · ·			M	2. Date of Dea Month [arch ]	, 20	800	ar 9	3. Time of Death
Examin	er	4a. Facility Name (If not institution, Bel-Pre Health	-			Silv	ver	Sprin				Ontgom		
Funeral Director	ij	5. Social Security Number 579-20-3184 Usual Residence of Decedent	5. Sex 1 □ M 21x F	7. Age (In yrs. 97	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Date			Country)	e (State or Foreign ) ngton, d.(
the Maryland 28a-f show notified at	tor	10a. State 10b. County  D • C •			ty, Town or Lo								10d.	Inside City Limits 1 ☐ Yes 2 ☐ No
be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral Director	10e. Street and Number 6500 7th P1. N.  11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dec Armed Fo d 1 Tyes If Yes, Gi Year or D	2 No		Was Decedo if Yes, speci 1 Yes 2	0012 ent of Hi ify Cuba	ispanic Ori in, Mexicar Specify:	gin? (Spec n, Puerto F	cify Yes or No lican, etc.)	-		Sta merican /hite, etc Blac	indian,
within 72 h ene. than "nati he Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (	1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use pital:	k done d e retired	during mos  )				ind of Busine		
be sd of se	To Be Co	17. Father's Name (First, Middle, L William Brook			1105	ртіат.	ILY		er's Name	(First, Middle,		rivate Surname)	:_Inc	lustry
s 1 and 2 should be f Health and Mental item 27 is marked c other traumatic eve		19a. Informant's Name/Relationshi			6500	7th P	1. N	.W. W		Route Number				ode)
permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			Place of Dispo cemetery, crei ncoln	Memor	ial	3	3/6/2		Su	ocation - City itland	, Md	
permit. Departimports any inj		21. Signature of Funeral Service L	Savan	M010	55 2	2. Name and 5538	Addres ande Mar	ss of Eacilit Tborc	PPPE	ė/Porės	stvi	11e, M	_	20747
Physician /Medical		23a. P. I. T. E ter the diseas , or o shock, o heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cau e on e a. Sen	caused the deaf each line. ile Deb (or as a consec	ility	ter the mode	e of dyin	g, such as	cardiac or	r respiratory a	rrest,		A In	pproximate Iterval Between Inset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury	b	(or as a conseq										
ate be executed hysician and the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to	(or as a consec	quence of):									
ath certific ittending p or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐Live I	tcome pf pregn birth 2 ☐ Feta nant at time of c own	aldeath 3	□Ectopic pre		,				23d. Date of Month	delivery Da	ay Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition Osteoporosis	s contributing to d	eath but not res	sulting in the u	nderlying ca	use give	en in Part I.						cause of death? ly 4 ∐Unknown
The law requate has been page 2 should	Completed								<del></del>	24a. Was autor perfo 1□ Yes	psy rmed?	prior death	to comp h?	y findings available letion of cause of
ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)	'		
Physic this ce al dire	To	1 ☐ Yes 2★☐ No	_		ER/Outpatier			4 & NU		ne 5□Resid		<u>`</u>	Specify)	
ttending Physician: The leath. stor: After this certificate he the funeral director, page	Certification:	27. Manner of Death  12 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	tion and the last place	of Injury oth, Day Year)	28b. Time o	М	-	yat k? Yes 2∐	No	8d. Describe I			, D 1 **	Zoudo Niverbr
To the Hospital or Attending within 24 hours atter death.  To the Funeral Director: After completely filled in by the fune		4 ☐ Homicide determin	Zoe. Place	e of injury - At h ing, etc. (Speci	fy) 			ne data s	4,1	City or Tov	wn, State	e)		Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 ☐ Medical E	xaminer: On the b	e best of my kno basis of examina iner stated.	ation and/or in	vestigation,	in my o	ne, date ar pinion, dea  e number	ath occurre	and due to the	date an	d place, and	due to th	ne cause(s)
0 7 M 7	2	29b. Signature and title of certifier	ne A	ulfa	γO		D566					rch 4,		_
43)		30. Name and addless of person w Ghousia Sult	ana, M.D	. 1210	7 Heri		Park	Circ	ele S	ilver S	Spri	ng, Md	. 2	20906
Sta	te	31. Date filed (Month, Day, Year)  MAR 0.7 2008	32. F	Registrar's Sign	Social !									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year 730 PM MARCH 2008 Α. evock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince Georges If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days **№** M 2□ F Hours 199-20-2978 Yrs. Director Nov 2 1925 Penna. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Tyes 2 No Maryland | Prince Georges Director New Carrollton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or ; must be r 6213 86th. Ave. 20784 Funeral U.S.A. an "natural", or Items Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after XXYes 2 No If Yes, Give Year or Dates: WXII 1 Never Married XX Married YNYes 2□No Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analytical Dept. Of Defense Stastician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Stephen Levock Mary Repasky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Levock (Wife) 6213 86th. Ave. New Carrollton, MD 20784 20a Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If any injury or Gate Of Heaven Cem. 3/10/2008 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral 9013 Annapolis Rd. Lanham, MD 20706 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** GNAL FAILURG disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner FAILURE MEARI Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examine led by the aftending physician and detached for use as the burial-trai burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ⊟Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) J90 03/06/08 MDD 50951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUE SUITE 2400 RIVERDALE MD 20737 6510 KENILWORTH alle 31. Date filed (Month, Day, Year) MAR 0 7 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore,

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March Physician 2008 Merrill Elwood Lahman, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CAMBRIDGE DORCHESTER GENERALHOSPITAL DORCHESTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 ☐ F Delaware Feb. 15,1925 Director 218-20-6711 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1XI XYes 2 □ No MDDorchester Hurlock Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21643 United States 45 Delaware Avenue #13 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 17 Yes 2 No If Yes, Give 44-46 Year or Dates: should be filed within 72 hours after and Mel tal Hygiene. 1 Never Married 2 Married White 1 ☐ Yes XX No Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Frito-Lay (Food) Route Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Monolia Franpton Elwood P. Lahman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Suzanne Lahman/Daughter 22652 Dover Bridge Rd., Preston, MD 21655 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Depa tment of Important; if Its any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/13/08 Eastern Sh. Veterans Hurlock, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Modernal Acortic Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence of) Due to Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ been signe should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? 1□ Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 TYes P 28b. Time of funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

within 24 hours arter com.

To the Funeral Director: Aff
To the Funeral Director: Aff

Division or Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of certifier

2008 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

XII



100

Pramble

29c License number

Dt.

29d. Date signed (Month, Day, Year)

cambridge MP

March 9, 2008

21215-0036

Baltimore, Maryland

TWAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Lot	artment of Health and Mei rtificate of Death	mai mygiene Reg. No. /	2000 2000
	Physici	an	1. Decedent's Name (First, Middle, Last) Howard Corkran Larrimore, Jr.		Date of Death Month Day	_ U U U 3. Time of Ceath. C
	/Medic	al	4a. Facility Name (If not institution, give street and number)	$F\epsilon$ 4b. City, Town, or Location of Death	ebruary 28	2008 5:25 P M
	Examin	er	107 Charles Street; Apt 4C	Sudlersville		en Anne
112	Funeral Director		5. Social Security Number  218-40-6078  0. Sex 1 M 2 F 65  1 Vrs. last birthday, 6. Sex 1 N 2 F 65  1 Vrs.	If Under 1 Year   If Under 24 Hrs.   8.   Months   Days   Hours   Min.   A	Date of Birth (Month Day, Year) Pril 19 19	9. Birthplace (State or Foreign Country) Maryland
	Maryland a-f show filed at	tor	10a. State 10b. County 10c. City, Town or Lo Sudlers v:			10d. Inside City Limits 1X Yes 2 □ No
	th with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 107 Charles Street; Apt. 4C	10f. Zip Code 21668	10g. Citize USA	n of What Country?
9800	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Tyes 2 M No	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Rici 1 ☐ Yes 2 ☒ No Specify:	can, etc.)	. Race - American Indian, Black, White, etc. Specify: White
15-0	יל 27 ה "natu edical	letec	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind	l of Business/Industry
12	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ck driver	l l	in hauling
Maryland 21215-0036	thould be filed and Mental Hyg marked other matic event, i	To Be C	17. Father's Name (First, Middle, Last) Howard C. Larrimore, Sr.		First, Middle, Maiden S nkins Larri	
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		Sharon E. Larrimore/ wife 107	ing Address (Street and Number or Rural R Charles Street; Apt	t 4C; Sudle	ersville, MD 21668
Baltimore,	permit. Pages 1 Department of H Important; If iter any Injury or ott		4 Donation 5 Other (Specify)	osition (Name of Date matery or other place) oro Cemetery 03/04/		stion - City or Town, State
Bal	permit Depar Impor any In		Depte Fu Fo	2. Name and Address of Facility leggle and Helfenber D Box 160 Greensbord		
		Z 0	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. META STATEMENT OF THE STATEME	LUNG CANCER	•	1 year
	Examiner		Sequentially list conditions b.			
	ted sit	nìner	Sequentially list conditions, if any list in limitation cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  c.			
ς,	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last c			
68760,	tte be iysicial ne buri	edical I	d			
			IF FEMALE:			
P.O. Box	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use it	Physician/N	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the LLIVER CLIZHUSIS	ınderlying cause given in Part I.	,	e contribute to the cause of death?  No 3 Probably 4 Unknown
Division or Vital Records,		Completed			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes ■ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (C		
0	ે છે. જે	٦. ا	27. Manner of Death 28a. Date of Injury 28b. Time of	11 3 DOA 4 Nursing Home	Residence 6 d. Describe how injury	
ion	Attending r death. ector: After by the fune	atlor	Month, Day Year) Injury  Accident investigation (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Divis	al or Atte s after de nl Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f	f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and nucestigation, in my opinion, death occurred	d due to the cause(s) a l at the time, date and p	nd manner as stated. place, and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
			I Son HIWINE MIS	D 004158-	1 3	3/2008
			30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. Helen A. Noble 122 Speer Road:	Print) Chestertwon, Maryl	and 21620	
	Sta	te	31. Date filed (Month, Day, Year) . Registrar's Signature	Mescerewon, maryr	.unu ZIUZU	
	Registr	ar	MAR - 5 2008			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 732 HAZEI 2008 MULLEN MAR 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death COLUMBIA WINTY GENERUM INSPITA 40WARD HOWARD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 1 F 75 Maryland 220-28-5526 April 24, 1932 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Prince Georges Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4635 Dallas Place Apt.# 203 20748 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Maintenance Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Freeland Anita Creek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7806 Sunny Lane, Forestville, MD 20747 Charlene Davis - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cooper's UM Church Cemetery: 3/11/2008 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maden a vell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be 1
Department of Health and Mental F.
Important: If item 27 is marked oth
any injury or other traumastra

**Physician** 

/Medical

**Examiner** 

10a. State

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-tran ed by the a detached f page

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

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	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the death. Do not enter t ne cause on each line.	he mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	a. SEPTIC SINGLE			2 WEEKS
	resulting in death)	Due to (or as a consequence of):			il .
		BACTEREMIA	+ (EscHeruca	inA cost)	4 MBEKS
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			31
ical Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑Mo 9 □ Unknown		topic pregnancy ther (specify)	23d. Date of o	delivery Day Year
d by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	e to the cause of death?  Probably 4 □Unknown
plete	DEMENTIA			24a. Was an 24b. Were prior	autopsy findings available to completion of cause of
Somp	ningeres mer	UTSS		performed? death	res 2 No
Be (	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
	1 Yes 2 V6	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Hor	me 5 ☐ Residence 6 ☐ Other (S	pecify)
Medical Certification: To	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury		28d. Describe how injury occurred	
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street building, etc. (Specify)	factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
dical (		sician: To the best of my knowledge, death or iner: On the basis of examination and/or inves and manner stated.			
Me	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mo	onth, Day, Year)

Hospital or Attending

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar 10724 LITTLE PATURENT PARKWAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

10

32. Registra Signature

MAND O. NYANJOM

MAR

31. Date filed (Month, Day, Year)

n 3697-4

MAR 2, 2008

COLUMBIA MID ZISTA

			For State Registrar	State o	of Marylar		rtment of F			ental Hy	giene			
-	-4-1	-	Registrar  1. Decedent's Name (First, Middle	e / set)		Cer	tificate of	Death		2. Date of D	Reg. No. 2	08	O C	221
	Physici		Virginia Franc	, ,	1					Month March	Day	Year	8:15	P <sup>M</sup>
4	/Medic Examir		4a. Facility Name (If not institution				4b. City, Town, o	or Location of		March	4c. County	of Death	0:13	_P_
1			Calvert County	Nursing (	Center		Prince	Frede	erick		Calv	vert		
	Funeral Director		5. Social Security Number 214–28–7698	6. Sex 1 ☐ M <b>②</b>	7. Age (In yrs.	. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, Di	rth ay, Year) <b>x</b> 13,1931	Coun	ace (State or try) land	Foreign
Т	w w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation	_				1	0d. inside City	/ Limits
	Maryl f sho	Į.	Maryland Calve	rt.		Lusby							1 □Yes	
	n the r 28a	Director	10e. Street and Number			Dabby	10f. Zip Code				10g. Citizen of	What Coun	try?	
	th wit		10670 Old Mill	Road			2065	57			United	State	es	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status  1 Never Married 2 Marr	Armed For ied 1 ☐ Yes if Yes, Gi	2 <b>X</b> No ve		Vas Decedent of H f Yes, specify Cub			cify Yes or Ne Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, o y: Whi	etc.	
9	2 hours atural" ical Exa	ted by	3 X Widowed 4 □ Divorced  15. Decedent	Year or D	ates:	16a. Deced	ent's Usual Occur	pation			16b. Kind of B			_
Maryland 21215-0036	vithin 7 ene. than "n e Medi	Completed	(Specify only highes Elementary/Secondary (0-12) 12	college (	1-4or 5+)	Postma	kind of work done OO NOT use retire	during mos d)	t of workin	ng	Indead O	bobos I	Dankal C	
р О	filed v Hygie Ither t		17. Father's Name (First, Middle,	Last)		Postnia	ster	18. Mothe	er's Name	(First, Middle	United S		ostal S	ervic
an	ould be f Mental I larked of	To Be	Malcolm Dowel	11						e Pard		/		
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street					State, Zip	Code)	
	1 and 2 Health em 27 I		Joanne Marie Sh	neran / Da		_	Old Mil	.1 Roa			MD 20657	7		
altimore,	Pages 1 a nent of Hee ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 📆 Cremation	3 ☐Removal from		Place of Dispos cemetery, cren	sition (Name of natory or other pla	сө)	Da	ate	20c. Location	- City or To	wn, State	
=	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (S		Mel		in Cremetor	4		2/08			ginia	
Ba	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service	Cour	DC/		O. Box 600				eral Home	, P.A.		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	caused the dea	th. Do not ente	er the mode of dyi	ng, such as	cardiac or	r respiratory a	arrest,		Approximate Interval Between	een
je.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	106	MONA	RY	En	NBO	LISI	7		Onset and De	auri
3	Examiner		roouning in dodary	Due to	(or as a consec	quence of):	/							
ı,	1 10	ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consec	quence of):						-	<del></del>	
	cuted nd ransit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
60,	icate be executed physician and the burial-transit		resulting in death) Last	Due to	(or as a consec	quence of):					_			
38760	icate t physic	dical		d										
O. Box (	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	tcome pf pregn birth 2 □ Feta nant at time of c own	al death 3	Ectopic pregnanc Other (specify)	у				te of delive	,	ear
٦.	that the ed by detac		Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the un	derlying cause giv	en in Part f.		23e. Did	tobacco use con	tribute to th	e cause of dea	ath?
ords	w requires that s been signed t should be deta	ted by	SEVERE	ALZHE	IME	R'5	DE	MEN	TA	1 🗆	Yes 2100	3 ☐ Prob	ably 4 □Un	ıknown
Records,	sician: The law r certificate has be irector, page 2 sh	Completed				<del>-</del>					psy ormed?	prior to con death?	osy findings av	/ailable use of
Vital		BeC	25. Was case referred to medical examiner?					26. Place	of Death	1□ Yes (Check only	A	I 🗆 Yes	2   NO	
	hysic this ce al dire	2	1 ☐ Yes 2 No			ER/Outpatient		4 L Nu	rsing Hom	ne 5□Res	idence 6 □Oth	ner (Specify	)	
DIVISION OF	ding P	ion:	27. Manuer of Death  1 Natural 5 □ Pending		of Injury th, Day Year)	28b. Time of injury	28c. Injur Wor M 1			8d. Describe	how injury occur	red		
1310	Attender death	ficat	2 Accident investig	not be 28e. Place	of injury - At h	ome, farm, stre	et, factory, office	Yes 2□		8f. Location (	Street and Numl	per or Rura	Route Numbi	er.
2	tal or /	Certification:	4   Hornicide	buildi	ng, etc. (Speci	fy)				City or To	wn, State)			51,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medicai	g Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the tile estigation, in my o	me, date an opinion, dea	nd place, a ath occurre	nd due to the ed at the time	cause(s) and m , date and place,	anner as st and due to	ated. the cause(s)	
	To the Comit	Ň	29b. Signature and title of certifier	lysti	M	2	29c. Licens	e number			29d. Date signe	d (Month, l	Day, Year)	01
)				Allender	of Fh	ysic.	- 1919	142	Z		3 -	10 -	200	δ,
K	06		A.I. Munshi, N	tho completed caus	OSPITA	LDR	ve Ste.	303,	PRIM	nera	edsexk	Mi	206 78	7
	Sta Registr			1 0 2008	egistras Signa	w K	Could	E						

			For State	State o	f Marylar				and Mental		your your you you	0.0	001
		-	Registrar  1. Decedent's Name (First, Midd	tle (ast)		Ce	rtificate of	Death			No2008	109	772
· ·	Physic		Phillip	Miller					2. Date of Month		Day Year	3. Time o	M
	/Medi Exami		4a. Facility Name (If not institution		mber)		4b. City, Town,	or Location	February of Death	uary	29, 2008 4c. County of Death	9:46	A IVI
			Washington Ad	iventist H	ospital		Takoma	Park			Montgome	ry	
	Funeral		5. Social Security Number	6. Sex 1 XM 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days			f Birth 7, Day, Ye	9. Birth	place (State	or Foreign
	Director		579-24-6761 Usual Residence of Decedent	12411 221	82	Yrs.			Sept	. 14,	, 1925 Was	híngto	on, DC
	yland now at		10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	cation					10d. Inside C	ity Limits
	a-f st	ţ	District of (	Columbia		Washin	gton					1 ⊠Yes	2 □ No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Cou	ntry?	
	ath w		5527 Kansas				200			U	nited Stat	tes	
	ter de item ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Appled Fo		.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Or oan, Mexica	igin? (Specify Yes on, Puerto Rican, etc	r No- .)	14. Race - Ameri Black, White,		
36	ırs aft al'', or 'xami	by	3 Widowed 4 Divorce	If Ves Gi	/e		1□Yes 2█ No	Specify:			Specify:	31ack	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decede	nt's Education	·	16a. Dece	dent's Usual Occu	pation		16b	). Kind of Business/In		
215	thin 7 le. lan "r	nple	Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)		kind of work done DO NOT use retire					,	
21	led wi lygier ner th	Con	8 years			Depar	tment of		Employee		Government		
and	l be fil ntal H ed ott	Be	17. Father's Name (First, Middle	, Last)					er's Name (First, Mi		den Surname)		
Ž	hould d Mei marke	To	Lott Miller  19a. Informant's Name/Relation	chin (Tuno Print)		10h Mailie	- Add (04		cille Cla				
Ma	nd 2 s Ith an 27 Is		Aileen Oliver								ity or Town, State, Zip, MD 20910		
ē,	es 1 ar of Hea of Item 3		20a. Method of Disposition	Cousin	20b. F		sition (Name of natory or other pla		Date Date		Location - City or To		
altimore,	permit. Pages Department of Important: If i any Injury or once.		1X Burial 2 □ Cremation 4 □ Donation 5 □ Other (	3 □Removal from Specify)	State				Mars 0 20	0	Clana 1 - 4 4		77 A
alti	permit. Departn Importa any inju		21. Sign, ture of Funeral Service		1013	11 Fall	Name and Addre	ess of Facilit			Charlottes eral Home,		, VA
<u>B</u>	8 8 E 8 8	150	Men	water V	1 EVIDE	1) 4	001 Benn	ing R			ngton, DC		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that c t only one cause on e	aused the deat	h. Do not ente	er the mode of dyi	ng, such as	cardiac or respirato	ry arrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	Say	1951 S						Onset and	Death
7	/Medical Examiner	Ш	resuring in death)	Due to	or as a conse								
		ja l	Sequentially list conditions,	b	or as a consequence	17	ri/Ur	1					
	uted d ansit	Examiner	Sequentially list conditions, it is a superior of the cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>									
o,	be executed ician and burial-transit	Exa	resulting in death) Last	CDue to (	or as a consequ	uence of):							
8760,	icate be executed physician and the burial-transit	dical		d									
9	ertifica ling pl e as t	Med	IF FEMALE:	1		_		_					
Вох	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	I death 3	Ectopic pregnanc	у			23d. Date of deliver	-	Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time of down	eath 5	Other (specify) _			_	WOITH	Day	i eai
	that I	h h	Part II. Other significant conditi	ons contributing to de	ath but not resu	Ilting in the un	derlying cause giv	en in Part I.	. 23e. [	oid tobacc	co use contribute to t	ne cause of o	death?
Records,	w requires that the di been signed by the should be detached	Completed by							1	☐ Yes	2 No 3 Prot	pably 4	Inknown
တ္တ	aw re is bee	olete							24a. V	Vas an	24b. Were auto	psy findings	available
Ä	The law ate has be	mo:							a p 1□ Ye	utopsy erformed	prior to co death?	mpletion of c	ause of
Vital	ctor,	Be C	25. Was case referred to medica examiner?					26. Place	of Death (Check or		TIL TES	ZIANO	- 1
J.	Physician: this certific	P L	1 ☐ Yes 2 ☐ No			ER/Outpatient		4 🗀 Nu	rsing Home 5 🗆 F	Residence	6 □Other (Specif	y)	
Division or	ding F	ioi	27. Manner of Death 1≀7 Natural 5 ☐ Pendir		of Injury h, Day Year)	28b. Time of Injury	28c. Injur Wor			be how ir	njury occurred		
isi	Attending r death. ector: After by the funer	icat	2 Accident investi 3 Suicide 6 Could		of injury - At ho	me farm stre		Yes 2 ☐ I		- (04 4	and Months on B	(B	
Ö	after after I Dire d in b	Certification:	4 ☐ Homicide determ	buildir	ng, etc. (Specify	()	et, factory, office			Town, St	and Number or Rura ate)	ii Houte Num	iber,
	pspitz hours unera ly fille		29a. Certifier 1 ★ Certifyir	ng Physician: To the	best of my know	wledge, death	occurred at the tir	me, date an	d place, and due to	the cause	e(s) and manner as s	tated.	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	Examiner: On the ba and mann	er stated.	tion and/or inv	estigation, in my c	opinion, dea	th occurred at the ti	me, date	and place, and due to	the cause(s	5)
	To To To To	2	29b. Signature and title of certife	1)04	18 P	6	29c. Licens	e number	111	29d. [	Date signed (Month,	Day, Year)	~
			/	n.2)	100	-K	1	147	7+1		12/36	1/20	Ray
1)	(10)		30. Name and address of person	who completed cause	of death (Item	23a) (Type, F	Print)	1.1	1 C: 1.		a c1	C1.	
	Sta	te	31. Date filed (Month, Day, Year)	32. Ac	egiştrar's Si nat	tur	ma	-1)	1 shy	M	3 14.	) tu	214
	Registr	.~	MAR 0 6 2008	Blown X	K Apo				•		/		
	-												

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-09226 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 3-4-08 Bay BOOKER McDONALD, JR. Τ. 10:29 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE 6. Sex Date of Birth (Month, Day, Year) 3-8-46 Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**☆**M 2□F <u>579~56-</u>5116 61 WASH., DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1¶Yes 2□No **CHARLES** WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4404 COTUIT CIRCLE 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 YRS. (1-4or 5+) BUILDING ENGINEER PSI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BOOKER McDONALD, SR. IRENE BOONE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLIE A. McDONALD-WIFE 4404 COTUIT CIRCLE WALDORF, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

OTH CT

3-7-08

22. Name and Address of Facility PINCKNEY-SPANGLER F. II.

CLINTON, MD

**Physician** /Medical

**Physician** 

Examiner

Funeral

Director

show.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

death with the Maryland

/Medical

10a. State

MD

1 ☐ Burial 2 【XCremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

1/2

Director

Funeral

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Completed

Be

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Examiner

attending p page

The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

	Moderal	, with	- om or., w.	E. WASH.,	DC 20002-3236
	Shock, of heart failure. List only	nplications that caused the death. Do not enter the	e mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. Rumona	Aboustic with	Mertmin	Onset and Death
	<b>1</b>	Due to (or as a consequence of):			
ıminer	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events	b. Plue to force a our sequence off-			
ical Exa	resulting in death) Last	Due to (or as a consequence of):			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of delivery Month Day Year
y P	Part II. Other significant conditions	contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ed b				1 ☐ Yes	2 No 3 Probably 4 Unknown
Complet				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?	Hoppital:		ath (Check only one)	
6	1 ☐ Yes 20 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3		lome 5 ☐ Residence	
ation	1 Natural 5 □ Pending 2 □ Accident investigation	- 4	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		actory, office	28f. Location (Street a City or Town, Star	nd Number or Rural Route Number, e)
Medical Certification: To	29a. Certifier 1 Certifying Ph (Check only one) Medical Exar	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place ation, in my opinion, death occu	e, and due to the cause( urred at the time, date ar	s) and manner as stated. Id place, and due to the cause(s)
Σ	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)
	•		0006h81		3/4/8
	Chavin Po	completed cause of death (Item 23a) (Type, Print)	atts Rd.	Clinton	md 20735
te ar	MAR 0 6 2008	32. Registrar's Signature			,

LEE CREMATORY

DHMH 17 Rev 1/2001

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year P<sub>M</sub> Terry Malvin  $\Pi$ March 1, 2008 9:11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Center Silver Spring Mantgarery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**⊠**M 2□F 284-07-4561 89 Director April 10, 1918 Chio Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show items 23a or 28a-f show iner must be notified at Lanham 1X Yes 2 No MD Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20706 5703 Barker Place U.S. by Funeral 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1\_5\_46 1 ☑ Yes 2 ☐ No If Yes, Give 1\_4\_49 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 1 ☐ Never Married 2 X Married African American ö altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once, Elementary/Secondary (0-12) College (1-4or 5+) U.S. Covernment U.S. Postal Service Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dale Malvin Mattie Mae McCall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5703 Barker Pl., Lanham, Maryland 20706 Clara M. Malvin-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ★Burial 2 Cremation 3 Removal from State 3-8-08 Landover, MD Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bornette & Assoc. Funeral Home Inc. 21. Signature Funeral Service Licensee 2504 28th St., N.E., WDC 20018 236. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician End-Stage Cardionyopathy** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has birector, page 2 s autopsy perform 2 X No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director; After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 21X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural nours after death. Ineral Director; Af y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number D0057362 March 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jean Hou, ...
31. Date filed (Month, Day, Year)

4AR n 6 2008 1500 Forest Glen Rd., Silver Spring, MD 20910 32. Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

		1- State of Maryland / Department	artment of Health and M rtificate of Death	ental Hygiene
	*	Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death
Physic /Med		Marie Maull Murray		March 8, 2008 12:02 P M
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	10	1008 Lapidum Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Havre de Grace If Under 1 Year   If Under 24 Hrs.	Harford  8. Date of Birth  9. Birthplace (State or Foreign)
Funera Director		5. Social Security Number  6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  Nov. 18, 1922  Pennsulvania
pun	7	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
/anyla f shored at	٥	Maryland Harford Havre de		1 □Yes 2 No
the N 28a- notifi	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
h with	a D	1008 Lapidum Road	21078	u.s.A.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at annous	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces 20 No.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
thin 72 hours afee. an "natural", or	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	
led wi lygier her th			ry Cataloger	Government  (First, Middle, Maiden Surname)
ntal H	Be	17. Father's Name (First, Middle, Last)	Marie R.	
should nd Me mark matic	2	Harry C. Maull  19a. Informant's Name/Relationship (Type. Print)  19b. Mailir		al Route Number, City or Town, State, Zip Code)
nd 2 sulth ar 27 is		1 1 2 2	ack Bass Trail, Fa	irfield, Pennsylvania 17320
ss 1 all of Hear item		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date of Matory or other place)	Date 20c. Location - City or Town, State
Page nent c		1 Di Bunai 2 i Cremation 3 i Removal from State 1	l Cemetery 3/12/	2008 Havre de Grace, MD
permit. Pages Department of Important: If it any injury or o				lman Funeral Home, P.A. St. Havre de Grace, MD 21078
cate be executed Examiner  physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
death certifi e attending d for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
The law requires that the te has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
The law requires tate has been signed page 2 should be	Completed			24a. Was an autopsy performed?  1 ☐ Yes 2 No   24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 No
Physician: Tribis certificat	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	h (Check only one)
Phys r this ral dir	<u>٩</u>	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2. ☐ Manner of Death 28a. Date of Injury 28b. Time of Death	TIL 3 DOA 4 Nursing Hol	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Attending ar death. rector: Afte by the fune	Certification:	1 → Watural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Cert	29a. Certifier (Check only (Ch	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause(s) and manner as stated.
the H hin 24 the F mplete	Medi	and manner stated.	29c. License number	29d. Date signed (Month, Day, Year)
vit To	-	29b. Signature and title of certifier	054756	MARCH 11 2000
		30. Name and address of person who completed cause of death (Item 23a) (Type, Robert Ropp, Jr., M.D. 2027 Pu	y laski Hwy, Suit	re 203, Haure De Grace, MO
S	tate	31. Date filed (Month Ryear) 2 2008 32. Reistrar's Signature	Brooks	200

Age (In yrs. last birthday,

10c. City, Town or Location

4b. City, Town, or Location of Death

If Under 24 Hrs. Hours Min.

1 Year Days

09229

30 PM

3. Time of Death

IE

Birthplace (State or Foreign Country)

10d. Inside Gity Limits

4c. County of Death

8. Date of Birth (Month, Day,

Physician /Medical Examiner

Name (If not institution, give street and number)

10b. County

**Funeral** Director

10a. State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

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al Dire	10e. Street and Nur	mber 3PEV2	AVE.		10f.	Zip Code 21632		10g. (	Ditizen of What Co	ountry?
ıner	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was De	cedent of Hispanic O	rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
by Fu	1 ☐ Never Marri 3 ☑ Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	<b>1</b> 0		Specify		,	Specify: U	HITE
etec	(Spec	15. Decedent's I	Education rade completed)	16a.	(Give kind of	sual Occupation work done during mo	st of working	16b.	Kind of Business/	/Industry
Sompl	Elementary/Seco	ndary (0-12)	College (1-4or 5	i+)	HOW	IEMAKE	72	01	UN HO	ME
To Be Completed by Funeral Director	17. Father's Name (	(First, Middle, Las VILLE	EUS			18. Moth	ner's Name (i	First, Middle, Maid E HIU	en Surname)	
	19a. Informant's Na KARENHA	ame/Relationship	(Type. Print) DAUGHTE		Mailing Addr	NEFT.RD.	ber or Rural i	Route Number, Cit	DE O	zip Code) 1950
			□Removal from State	20b. Place of cemete	Disposition (Introduction (Introduction)	Name of or other place)	3/3/0	te 20c.	Location - City or	Town, State
	21. Signature of Fu	ineral Service Lic	ensee		22 Name	and Address of Faci	FULL	PAL HOM	Emo:	21632
	shock, or hea Immediate Cause (	ırt failure. List onl Final	mplications that caused y one cause on each lir	the death. Do		node of dying, such a		respiratory arrest,	<b>L</b> i & .	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	•	a	a consequence		ocar av	S- 1	14 ( 2.chc.	TION.	
Completed by Physician/Medical Examiner	Sequentially list collections cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	rilying injury	c	a consequence						
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ysician/M	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 1 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopi 5 □ Other	c pregnancy (specify)			23d. Date of de Month	livery Day Year
l by Ph	Part II. Other signif	ficant conditions	contributing to death be	ut not resulting i	n the underlyir	g cause given in Part	I.	23e. Did tobacc	N	o the cause of death? robably 4 □Unknown
letec								24a. Was an		utopsy findings available
Comp								autopsy performed 1∐ Yes 2	prior to death?	completion of cause of
Be	25. Was case refer examiner?	red to medical	Hospital:			Other		(Check only one)		
n: To	1 ☐ Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-	28a. Date of Inju	ry 28b.	itpatient 3  Time of injury	28c. Injury at Work?		e 5 Residence d. Describe how in		ecity)
catic	2 ☐ Accident	investigati	on		М	1 ☐ Yes 2 ☐	1 .1	M I apption (Ctrast	and Number or D	ural Route Number.
Certifi	4 ☐ Homicide	determine	28e. Place of inju	c. (Specify)	iiii, sileet, lac	tory, office	20	City or Town, St		urar noute Number,
Medical Certification: To	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis o and manner sta	f examination ar						
Š	29b. Signature and	title of certifier		m	D	29c. License number			Date signed (Mon	th, Day, Year)
	30. Name and addr		o completed cause of d	leath (Item 23a)	(Type, Print)	eve Pr				
te	31. Date filed (Mon	15 00	4 2008 Regist		B A					
ar		MINNE.	- 4 FA00			1000000				

DHMH 17 Rev 1/2001

State Registrar

			For State Registrar	State of Marylar	-	artment of F rtificate of I			ene g. No. 2 A A R	00000
F		4	Decedent's Name (First, Middle, Last)	)				2. Date of Death	1	3. Time of Death
	Physicia /Medic		SUSIE	1	N. NE	AL		MARCH	2 2008 Pear	10:20 PM
	Examin	er	4a. Facility Name (If not institution, give SOUTHERN MARYLAN			4b. City, Town, or CLINTO	r Location of Death		4c. County of Death	
and the same	Funeral Director	200	Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MARCH		place (State or Foreign intry) RGINIA
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl a-f sho fied a	tor	MD PRINCE (	GEORGE'S	UPPER	MARLBOR	0			1 Yes 2 No
	ith the or 28%	Direc	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	untry?
	sath w	eral	10317 WELLSHIRE I	DRIVE  12. Was Decedent Ever in U	IS 13 1	20772	lispanic Origin? (Sp		USA 14. Race - Amer	ican Indian.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
2-0	72 ho "natur dical I	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	tent's Usual Occup kind of work done	ation during most of work d)	ring	6b. Kind of Business/I	ndustry
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ylaı	ould b Menta larked latic e	To Be	EXTRA POWELL		1			CHANDLE		
Maryland	id 2 sh th and thand traum traum		19a. Informant's Name/Relationship (T)  NANCY JONES/DAU						City or Town, State, Z	YLAND 20772
ē,	s 1 an of Heal Item 2 other		20a. Method of Disposition	20b.		sition (Name of matory or other place			20c. Location - City or	
<u>E</u>	Page ment c ant: If ury or		1 ∯Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Temovarirom State   DE	SURRECT	CION CEME	TERY 3/8/	2008 C	LINTON, MAR	YLAND
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licens  **DUGGENERAL COMMON COMM	ud	1 7		OVER ROAD	LANDOVE	KINS FUNER	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of					or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a		LNFARCTIO	N			
	Examiner			DENENTIA	querice or).					
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68760,	ficate be executed g physician and is the burial-transit	edical E		d						
		Medi	IF FEMALE:							
P.O. Box	law requires that the death certi as been signed by the attending 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other <i>(specify)</i>	у		23d. Date of deli Month	very Day Year
	uires that t signed by d be detad	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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or	Attending Physician: r death. ector: After this certific by the funeral director,	-: To	1 X Yes 2 No  27. Manner of Death	28a. Date of Injury	XER/Outpatier 28b. Time o		4 LI Nursing H		nce 6 Other (Spec	cify)
on	nding I tth. r: After e funer	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No			
Division or Vital Records,	i de de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci		reet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical C		/sician: To the best of my kn iner: On the basis of examin and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11/		29c. Licens	se number	2	9d. Date signed (Monti	h, Day, Year)
/			· vely y	were		D227	80		MARCH 4	, 2008
12	- (3)		30. Name and address of person who o				DRIVE # /	SO CDEEN	BELT, MARYL	AND 20770
	48	the	31. Date filed (Month, Day, Year)	32. Registrar's Sign		- CENTEK	DKTAG # 7	IJJAR OCH	THATL	41111 ZUIIU
	Prograti	er i	MAR 0 6 2008	Kenny H	diane	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar		State of Ma			ificate of L				g. No. 2	0.08	092	31
	Bharlei	TATE OF	1. Decedent's Name (First,	Middle, Las	1)					2.	Date of Death Month	ı Day	Year	3. Time of D	eath
	Physicia /Medic	_		Heler	n West	Р		ton			ebruary	26,		9:20	Α Μ
	Examin		4a. Facility Name (If not inst		street and number)			4b. City, Town, or	Location	of Death			unty of Death	Δ	
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Ŀ	Funeral Director		212-18-2525 Usual Residence of Decede	1[	M 2 □ F		rs.	Months Days	Hours		(Month, Day, gust 8, 19		Cour	ryland	
	land ow		10a. State 10b. C			10c. City, Town	or Loca	ation					1	0d. Inside City	
	Mary a-f sh fled	tor	Maryland Ba	1timo	re	Towso	n							1x□Yes 2	≧□No
	th the or 28g	Director	10e. Street and Number					10f. Zip Code				•	of What Cour		
	23a ust b	rai	1 Smeton Pla	ce	Apt. 1002			21204					States Race - Americ	of Ame	rica
	er dea items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐	Marriad	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N		13. W	as Decedent of Hi Yes, specify Cuba	ispanic C an, Mexic	an, Puerto Ric	y Yes or No- an, etc.)		Black, White,	etc.	
36	rs aft I", or xamil	by F	3 Widowed 4 □ Div		If Yes, Give Year or Dates:	10	1[	□Yes 2Ñ No	Specif	y:		Sp	<sup>pecify:</sup> Cauc	asian	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ted	15. De	cedent's Ed	ucation de completed)	16a. I	Decede (Give ki	ent's Usual Occupa	ation	ost of working			of Business/In		
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and	i be fil ntal H ed otl	Be			D - : 1 D					•	ına Spa		···/		
ž	hould nd Me mark matic	은	Mars  19a. Informant's Name/Rel		Bailey Dow Type. Print)		Mailing	Address (Street a					own, State, Zij	Code)	
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Ē,	s 1 ar		20a. Method of Disposition			20b. Place of cemeter	Disposi	ition (Name of atory or other place		Date			tion - City or T		
Ë	Page nent c int: If		1 ∰ Burial 2 □ Crem 4 □ Donation 5 □ Ot	ation 3 ∐ ther ( <i>Specif</i> )	Removal from State	Denton			1	3/1/20	008 D	ento	n, Mary	·land	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Monatur of Funeral S	ervice Licen			22. Mo	Name and Address	ss of Fac era1	Home.	P.A.				
_	99 = 29		Janese!	Jan 1	Hocz		1 10	South S	Seco	nd Stre	eet. DE	nton	, Maryl	and 216	529
			23a. Part1. Enter the dise	ase, or comp a. List only	one cause on each li	ne.	ot ente	r the mode of dyin		as cardiac of T	espiratory arre	751,		Approximate Interval Betw Onset and De	een eath
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	м	10001		ic In	770	ik CTT	on				
	Examiner					consequence o	11).								
	18	Je.	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ě	b. Line to (or as	a cunséquence o	f):								
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	1	C										
, 0	tificate be executed g physician and as the burial-transit	Ä	resulting in death) Last		Due to (or as	a consequence of	it):								
68760,	cate b physic the b	edical			d										
Вох 6			IF FEMALE: 23b. Was decedent pregna	ant	23c. If yes, outcome	pf pregnancy 2 □ Fetal death	3□	Ectopic pregnancy	v			230	d. Date of deliv		
	ed for	Physician/M	in the past 12 months 1 ☐ Yes 2 No		4□Pregnant a			Other (specify)	у				Month	Day Y	ear
P.O.	at the d by the etach	Phy	9 ☐ Unknown  Part II. Other significant c	enditions (		ut not resulting in	the un	derlying cause giv	en in Pa	rt I.	23e. Did tot	bacco use	e contribute to	the cause of de	eath?
Records,	The law requires that the death cer tte has been signed by the attendin page 2 should be detached for use	5						acity in graduate give		<u></u>	1 □ Y		/		nknown
eco	law re as bee	Completed									24a. Was a autops	SV	24b. Were aut	topsy findings a ompletion of ca	vailable use of
<u>=</u>		Co									1 Yes	med? 2 X No	1 ☐ Yes	6€ No	
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to rexaminer?	nedical	Hospital:			Oth	or:		Check onl on			w.)	
0	Attending Physician: r death. ector: After this certific by the funeral director,	P	1 Yes 2 No 27. Manner of Death		28a. Date of Inju	ıry 28b. T	ime of	28c. Injul	4 🗆		d. Describe h		☐Other (Spec	ату)	
O	th. th: : Afte	tion		Pending investigation	(Month, Da	ay Year) II	njury		rk? ] Yes 2	□No					
Division or Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:		Could not be determined	28e. Flace of Itt	jury - At home, fai tc. (Specify)	rm, stre	eet, factory, office		28	f. Location (Si City or Town		Number or Ru	ral Route Numi	ber,
_	ospital hours a uneral ly filled		29a. Certifier 12 C	ertifying Ph	nysician: To the best niner: On the basis of	of my knowledge	, death	occurred at the ti	ime, date	and place, ar	nd due to the o	ause(s) a	and manner as	stated. to the cause(s	)
	the H nin 24 the Fi nplete	Medical	one)		and manner st			29c. Licens					signed (Month		
	Mait To Con	2	29b. Signature and title of	certifier	St. 16	Mr		1) 2		3 /17		2	1261	28	
			30. Name and address of	person who	completed cause of	death (Item 23a) (	Type, I	Print //		11.	MD.	31	62		
			1441 7	OCK	100%, 50	1, 60 V	)	with.	eu	1112,	1411.	+10	73		
	St Regist	ate rar	31. Date filed (Month, Day		-88	rar's Signature		70							

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AS 12

		For State Registrar	State of Maryland /	Department of H Certificate of I			iene <sub>eg. No.</sub> 2 (	008	09232
Physic /Medi		1. Decedent's Name (First, Middle, Las DORIS S. RHII				2. Date of Dead MARCH		2088	3. Time of Death <b>6:55P</b> M
Exami		4a. Facility Name (If not institution, give HOLY CROSS HOS	SPITAL	SILVE	Location of Death		MON	ity of Death  TGOME	
Funeral Director		230 10 3003	7. Age (In yrs. last b	yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 <sup>7</sup> 3°2	9. Birthpla Countr NORTI	ace (State or Foreign ry) H CAROLIN
Maryland -f show fied at	tor	Usual Residence of Decedent		wn or Location EST HYATTSV	'ILLE			10	d. Inside City Limits  XXYes 2 □ No
th the or 28a e noti	Director	10e, Street and Number		10f. Zip Code		1	0g. Citizen o	f What Countr	ry?
ath w \$ 23a sust t		5408-15TH PLA		2078		anifu Van or No	U.S	A ace - America	n Indian
Its after de	by Funeral	11. Marital Status  1 Never Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	Specify:	Rican, etc.)	В	lack, White, e	tc.
IDIC, INICITY INITY FIGURE 2. IN 2. IN 2. IN 2. IN 3.	Completed	15. Decedent's Ed (Specify only highest gra	de completed)  College (1-4or 5+)	ia. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	eation during most of work d)			Business/Indu	
ed wi		47 Faller Alexandria Least	<u>5+</u>	TEACHER	18. Mother's Nam				SCHOOLS
d be fill and H ced off	Be	17. Father's Name (First, Middle, Last)  JASPER E. SMI				KEYS	Walden Garri	arriey	
INICIPION DESPONDED PROPERTY IN AND MENTAL HY ZY IS MARKED OTH TRAUMATIC EVENT	P	19a. Informant's Name/Relationship (7		9b. Mailing Address (Street	-		r, City or Tow	n, State, Zip	Code)
T, INC 1 and 2 Health a em 27 Is		RAMON RHINEHA		5408-15TH.					
Dearmit. Pages 1 ar Department of Hea Mportant: If Item any Injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	cama	of Disposition (Name of tery, crematory or other place	ce)	Date	20c. Location	n - City or Tov	wn, State
Pages tment of tant: If ite		4 Donation 5 ☐ Other (Specify	) FT.	LINCOLN CE		0/08		TWOOD	
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	towart	6500 ALI	ENTOWN	RD. CA	MP SP		SERVICES , MD 2074
Physician /Medical		23a. Part1. Enter the disease of composition of the control of the	MULTI-INFA	RCT DEMENTI		or respiratory an	rest,		Approximate Interval Between Onset and Death
Examiner			Due to (or as a consequenc						
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	,					
ecute c	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ACUTE RENAI					-	
cate be executed physician and the burial-tran-it	dical Ex	resulting in death, East	Due to (or as a consequenc HYPERNATREM						
death certificate attending of for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		у			Date of deliver	ery Day Year
requires that the een signed by the hould be detache	d by Ph	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause giv	ven in Part I.			ontribute to th	ably 45 Unknown
1	Completed				-	24a. Was autop perfo 1 Yes	rmed?	prior to con death?	psy findings available mpletion of cause of 2 No
ian; ertifice ctor, p	Be	25. Was case referred to medical examiner?				th (Check only o	ne)		
Physician: this certific	2	1 Yes 2X No	Hospital: 1 XInpatient 2 ER/	Outpatient 3 DCA		ome 5 Resid			y)
Ilng P	inol	27. Manner of Death 1 Matural 5 □ Pending	(Month, Day Year)	b. Time of 28c. Inju Injury Wo M 1 □	iryaτ rk? ]Yes 2 □No	28d. Describe h	now injury occ	curred	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e Place of injury - At home			28f. Location (S City or Tov		mber or Rura	l Route Number,
Hospita 4 hours Funeral	Medical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at the t and/or investigation, in my	ime, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and date and pla	manner as st ce, and due to	tated. the cause(s)
To the I within 2.	Me	29b. Signature and title of cortifier		29c. Licen	se number		·	gned (Month,	
1		MUDIA	hell		2520		MARCH	6, 2	008
L(5)		30. Name and address of person who MARIA K. D'ARI	BELA,MD 1500 C	GLEN RD. SI	LVER SP	RING, M	D 209	10	
S	tate	31. Date filed (Month, Day, Year)  MAR 1 \( \) 2008	32. Registrar's Signature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** Herlinda 5:30 a M Rodriguez Feb. 28, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** 1□M 2₩F none 49 12/07/1958 Peru Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1∩a State 10h County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md. Montgomery Silver Spring M Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13210 Clifton Road 20904 Peru Funeral within 72 hours after death Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1⊠XYes 2□ No Specify: Peruvian Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) illed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important; If Item 27 Is marked other this any Injury or other them. Child-Care Provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Diego Cajahuaringa Margarita Flores 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Brother) 12337 QuailWoods Drive Germantown, Md. 20874 Johny Flores 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 03/04/2008 Beltsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Pacon CC 361 3447 14th Street, N.W. Washington, DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancet, disease or condition resulting in death) Lun a /Medical Due to or a consequence of): Examiner PNEUMONIZ Sequentially list conditions, and the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>Ş</u> 1 | Yes 2 INo 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed has certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 0 within 24 hours a To the Funeral L Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 2/29/ 006/681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10181 1 neu , MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)
MAR 1 0 2008

MAR 1 0

P.O. Box 68760 Division or Vital Records,

funeral director, Certification: To After this 1 Natural death. 2 Accident within 24 hours after death To the Funeral Director; filled in by the 3 Suicide 4 Homicide ō Hospital 29a. Certifier (Check only one) 29b. Signature and title of certifier State

29d. Date signed (Month, Day, Year)

1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D48158

mount & dul

6 Could not be determined

. OXON HILL MD 20745

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSIA, 6192 OXON HILL ROAD #500

31. Date filed (Month, Day, Year) MAR 0 7 2008 Registrar



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 2008 Ruth Margaret Reisinger March 8, 10:35A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Center for Hospice Care **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) Days Months Hours 1 □ M 2 👽 F 578-26-5942 Aug. 5, 1925 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 1 ☐Yes 2 No Maryland Howard Woodbine 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2445 Jennings Chapel Road 21797 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Specify: White 1 ☐ Yes 2 X No 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Clarence Reisinger Winifred Anna Renshaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2445 Jennings Chapel Road, Woodbine, Maryland 21797 Donna Owens 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/12/2008 Suitland, Maryland 4 Donation 3 Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Fun 26401 Ridge Road, Damscus, Maryland 20872 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hi art failure. List only one cause on each line. Approximate Interval Between Onset and Death EMENTIA Immediat Cause (Final disease or common icars resulting in death) Due to (or as a consequence of): 23d. Date of delivery □Ectopic pregnancy Day Month Year Other (specify) underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

Important: If item 2 any injury or other once.

Physician

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

"natural", or it

ed other than "nature event, the Medical

Director

Funeral

Completed by

Be 2

death with the Maryland

10:35 Am

March 8,2008

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: neral Director: /

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Certific

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

MAD

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Lifter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a consequence of):  Due to (or as a consequence of):
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Unb 9 Unknown  Part II. Other significant conditions		c. If yes, outcome pf pregnancy  1  Live birth 2  Fetal death 3  4  Pregnant at time of death 5  9  Unknown  ributing to death but not resulting in the
Be	25. Was case referred to medical examiner?	Но	ospital: 1 □ Inpatient 2 □ ER/Outpatie
cation: To	27. Manner of Death  ↑		28a. Date of Injury (Month, Day Year) 28b. Time Injury

2 No 3 Probably 4 Urlknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 1□ Yes

red to medical			2	6. Place of Dea	th (Check only one)	
Ne)	Hospital: 1 ☐ Inpatient 2[	☐ER/Outpatient 3☐ □	Other:	4 Nursing H	ome 5 Residence	Emother (Specify) ttos PICE
h 5  Pending investigatio 6  Could not b determined	e 29a Place of injury - At	M	28c. Injury a Work? 1 □ Ye ory, office		28d. Describe how inj	ury occurred and Number or Rural Route Number,
	hysician: To the best of my kr miner: On the basis of examinand manner stated.					(s) and manner as stated. nd place, and due to the cause(s)

within 24 hours a

Medical

555 W. I 32. Registra 31. Date filed (Month, Day, Year)

			Amended line #	19ар	er fh/t1			ertment of harmonic of the transfer of the tra			Reg. No.	0.8	09236
Е	Physic	ian	Decedent's Name (First, Noseph Editor)	iddie, Last)						2. Date of D Month Feb.		Year 008	3. Time of Death 2:20 P.M.
1	/Medi Exami		4a Fecility Name (If not instit 9901–A Longs			r)			4b. City, Town, or Rocky F	Location of Dea	th 4c. Count		
	Funeral Director		5. Social Security Number 054-30-5262	6. Sex	7. A	age (In yrs. lesi 88	t birthdey) Yrs.	ff Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth lay, Year) 1920		ace (State or Foreign y) linois
	and	•	Usuel Residence of Deceden 10e. State 10b. Cou			10c. City, T	own or Loc	cation					d. Inside City Limits
	Manyla	tor		deric	k		cy RI					10	1 ☐ Yes 2 ∏ No
	th the	lec	10e. Street end Number					10f. Zip Code			10g. Citizen of	Whet Counti	y?
	ath wi	<u>rai</u>	9901-A Longs	Mil1	Road			217	78		U.S.A		
020	urs efter de li', or flema kandner r	by Fune	11. Maritel Status 1 ☐ Never Merried 2 ☐ N 3 ☐ Widowed 4 ☐ Divor	Married	2. Wes Deceden Armed Forces 1 TyYes 2 If Yes, Give Year or Detes	?  No		Vas Decedent of H Yes, specify Cuba ☐ Yes 2☐(No		Specify Yes or N to Rican, etc.)	o- 14. Rad Bla Specif	ce - America ck, White, e <sup>'y:</sup> Whi	tc.
21215-0020	nit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland ertment of Heelth end Mental Hygiene. ortant: if item 27 is marked other than "natural," or items 23a or 28a-f show injury or other traumatic event, the Medical Evertinar must be notified at its.	Completed by Funeral Director	15. Dece (Specify only high Elementery/Secondary (0-1		etion	1		ent's Usual Occup kind of work done OO NOT use retired		orking	16b. Kind of B		
22	lied w tygier ther th		17. Father's Neme (First, Midd	llo I anti	12 ye	ars	Rese	earch Sci		(F)		icine	
lan	d be f	To Be	Edward Everet		1. Phd				Nell I		e, Maiden Suman	ne)	
ary	shoul and Ma s mari	٦	19a. Informant's Name/Relati	onship (Typ	oe, Print)		19b. Mailing	g Address (Street			ber, City or Town,	, State, Zip (	Code)
Σ,	end 2 selth c n 27 is		Pricilla Rall Priscilla	(I	aughter)		9901	-A Longs	Mill Ro	ad Rock	y Ridge,	Md.2	1778
Baltimore, Maryland	permit. Pages 1 end Depertment of Heelth Important: if item 27 any injury or other the		20a. Method of Disposition  1 ☐ Burial 2 ☐ Crematic  4 ☐ Donation 5 ☐ Other	(Specify)		ceme	hsbur	ition (Name of atory or other place g Cremat	ory	Date 3/1/08	20c. Location Smithsh	ourg,	Md.
Bal	permit. Page Depertment of Important: If any injury or once.		21. Signature of Feneral Perv		Jelly	P	<sup>22</sup> . R 6	Name and Addre OBERT E. 15 East	ss of Facility DAILEY Main St.	& Son Fi	uneral H nt. Md.	omes,	P.A.
	*		23a. Parts. Enter the disease shock, or heart failure.	or complic	ations that cause	d the death. Dine.						1	Approximate nterval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	е.	C	Due to (or as		ve H	eart	Fai	lune	1	onset and Death
	pe iis	lner		<b>a</b> b		240 10 (51 40	a contocqu	101100 017.				1	
68760,	To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, pege 2 should be deteched for use as the bunel-trensit	al Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events			Due to (or as							
Box 687	certificete nding phys use es the	n/Medical	resulting in death) Last	d.		Due to (or es	e consequ	ence of):					
, M	death e etter	sicial	Part II. Other significant cond	tions conti	ributing to death t	out not resulting	a in the und	dertving ceuse giv	en in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
s, P.O.	s that the gned by th	by Physician/M	AtrielF								Yes 2/2(No		bly 4 □ Unknown
Division of Vital Records,	lew require les been si 2 should l	Completed				,				24a. Wes	an autopsy ormed?	avail	autopsy findings able prior to pletion of cause eth?
E E	: The cete h	S								10	Yes 2. KNo	10	Yes 2□ No
5	sician certifi irecto	<b>60</b>	25. Was case referred to medi exeminer? 1 ☐ Yes 2. ★ No	_	spital:	• • • • • • • • • • • • • • • • • • •	0	Othe	26. Place of Dea				
סר	g Phy er this herel o	ñ: ٦٥	27. Manner of Death		28a. Date of Inju	ent 2 ER/	. Time of	28c. Injun	4 U Nursing F		dence 6 □Oth how injury occur	1-1	
SIO	endin eath. or: Aft the fur	atio		stigation	(MORRIT, De	y rear)	Injury		Yes 2 □ No				
Ĕ	or Att	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined	28e. Plece of In building, et	ury - At home, c. (Specify)	farm, stree	et, factory, office		28f. Location ( City or To	Street and Numb wn, Stete)	er or Rural I	Route Number,
_	Hospital 24 hours 6 Funeral ( etely filled	edical Ce	29a. Certifier 1 Certific (Check only one)	ring Physic al Examine	clen: To the best or: On the basis o and manner st	examination	ge, deeth o	occurred at the tim stigation, in my op	ne, date and place pinion, death occu	, and due to the rred et the time,	cause(s) and ma date and place,	anner as stat and due to t	ed. ne cause(s)
ı	To the To the comple	Me	29b. Signature end title of certi	ier				29c. License			29d. Date signe	d (Month, Da	ay, Year)
			Michael	2L	erner	M.D		DYI	619		Febru	avy	2909
	8		30. Name end eddress of person										
	-64-	0	Michael Le 31. Dete filed (Month, Dey, Yea			T.J. Di er's Signature	rive :	Frederic	k, Md. 2	1701			
	Sta Registra	G.		0 200	50		and the same	30/19					

DHMH 16 Rev 6/95

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

			1 - For State Registrar	State of I	Marylar		artment			ind Ment	_	giene	THUM	092	238
T	Physic /Medi		1. Decedent's Name (First, Middle Fannie D. Sewe							M	ate of De	ath Dar	Year Zooe	3. Time	of Death
	Exami		4a. Facility Name (If not institution		er)		4b. City, 1	Town, or L	ocation of				County of Dea		. /
	Funeral	Šž.	5. Social Security Number	6. Sex 7.	Age (In vrs.	last birthday)	If Under	,	n A  If Under 2	A Hrs. B. Da	ate of Bir	th		COMES thplace (State	or Foreign
1	Director		577 72 2926	1 □ M 2 🛱 F		53 Yrs.	Months		Hours	Min. 10/	te of Bir longs / I	954"	Wash	ington	,DC
	iand ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside	City Limits
	e Mary a-f sh iffied	ctor	DC		Was	shingto	n							1 □Ye	s 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 2918 P Street	SE			10f. Zip	Code 2	20020	)		_	ed Stat	-	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumetic event, Ina Medical Exartical must be nutified at	b	11. Marital Status  1 Never Married 2 Marr  3 X Widowed 4 Divorced	12. Was Decede Armed Force ed 1  Yes 2 If Yes, Give Year or Date	s? No		Was Decede f Yes, speci 1 Yes 2		oanic Orig Mexican, Specify:	in? (Specify Y Puerto Rican,	es or No etc.)	)-	14. Race - Ame Black, Whit Specify: BI	te, etc.	
1215-0	within 72 ho lene. than "natu ne Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1 2	's Education t grade completed)  College (1-4)	or 5+)	(Give	dent's Usual kind of work DO NOT use	k done dui e retired)	on ring most	of working			ind of Business	/Industry	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It is Mi	To Be Co	17. Father's Name (First, Middle, Willie Butler	ast)		Securi	ty Gu	1		r's Name (First e Georg		Maiden			
	1 and 2 should Health and Men em 27 is marke ither traumatic		19a. Informant's Name/Relationsh Hazel E Alfred		STER					or Rural Rout			r Town, State,	Zip Code)	
Baltimore,	Pages 1 and 3 nent of Health int: if item 27 iry or other tra		20a. Mathod of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (Sp		20b. F	Place of Dispo cemetery, cren	sition (Nam	e of her place)	i i	Date /7/2008		20c. Lo	ocation - City or		đ
Balti	permit. Page Department of Important: If any Injury or once.		21. Sonature of Funeral Service			22	. Name and	Address	of Facility	John T.	Rhf	nes	Funeral	. Home.	
Mayor	Physician		23a Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each	sed the deat	h. Do not ent	er the mode	of dying,	such as c	ardiac or resp	iratory ai	rrest,		Approxima Interval Be Onset and	etween
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):									_
	uted id	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or c	as a conseq	uence of):									
8760,	ete be executed hysician and the burial-transit		resulting in death) Last		as a conseq	uence of):									
O. Box 6	deeth certific e attending p id for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Feta at time of d	I death 3	Ectopic pre	gnancy ecify)					23d. Date of de Month	livery Day	Year
rds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditio	ns contributing to death	n but not res	ulting in the ur	nderlying ca	use given	in Part I.	2:			se contribute to	,	
of Vital Records,	The ate h page	Completed											prior to death?	utopsy finding completion of	s available cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to edical examiner?  1 Yes 2 No	Hospital:				Other		of Death (Chec					
ion of	ding h. After fune	-	27. Mann   f Death   1   atural   5   Pending   investig	28a. Date of In (Month, L		ER/Outpatien 28b. Time of Injury		ic. Injury at Work?	4 🗀 14013	28d. D			6 □Other (Spe y occurred	cify)	
Division	Ital or Attendins after deatlins after deatling Director: led in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	and 28e. Place of	Injury - At ho	ome, farm, stre	eet, factory,	office			cation (S ty or Tox		d Number or Ri	ural Route Nu	mber,
	Hosp 4 hou Fune ely fil	edical	one)	Physician: To the be xaminer: On the basis and manner	i of examina	wledge, death tion and/or inv	occurred a restigation, i	t the time, in my opin	date and ion, death	place, and du occurred at the	e to the	cause(s) date and	and manner as place, and due	s stated.	(s)
<b>\</b>	To the within 2 To the complet	Σ	29b. Signature and title of certifier	240				License n	umber	2			e signed (Mont		
2	(8)		30 Name and address of person v	no completed cause o	f death (Item	1 23a) (Type, I		35	12	/		07	7-26-20 Wrxt	200	
×10	Sta		31. Date filed (Month, Day, Year)		strar's Signa	Van A	(115	x	MI	> 7	· M	nES	Wix	aun	WD
20	Registr	dľ	MAR 0 7 200	House	15	A CONTRACT									

1. Decedent's Name (First, Middle, Last)

Emily

Virginia

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Speciale

<sup>Day</sup> 2008

Date of Death
 Month

March 6,

PM

7:00

10d. Inside City Limits

Approximate Interval Between Onset and Death

3 months

Year

White

1 ☐ Yes 2 No

Physician
/Medical
Examiner

**Funeral** Director

filed within 72 hours after death with the Maryland r 28a-f show notified at r than "natural", or Items 23a or the Medical Examiner must be r permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

physician and s the burial-trans use as To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Division or Vital Records, P.O. Box 68760

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Calvert Solomons if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Hours Months Days 1 □ M 2 🗶 F 215-14-5735 87 Maryland February 5,1921 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Director Maryland | Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1319 Bucks Lane 20657 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🛣 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Caterer Catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 Bucks Lane, Lusby, MD 20657 James R. Speciale / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middleham Chapel Cemetery 03/11/2008 Lusby, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. hickart P.O. Box 600, Lusby, MD 20657 arden Neva 23a. Part1. Enter the disealle, or comilications that caused the defin. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER LUNG Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? ş COPD. DM. CANCER COLON. HTN 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D36969 3/7/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCARIA MATHEW PUBOX 1789 LUSBY mD 20657

Registrar

State

31. Date filed (Month, Day, Year) MAR 1 0 2008

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2008 **Physician** Schenk March 8, 7:35 A M Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick College View Nursing Home Frederick 8. Date of Birth (Month, Day, Year)
April 16,1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 11 M 2 ☐ F New Jersey 129-14-2724 83 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

The state of the stat 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Funeral Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21701 USA 312 Selwyn Drive Apt. #2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 12∑Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1X Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 American Red Cross Chapter/Blood Service Rep. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Schenk (Unknown) William ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Beger/Niece 5513 Berkshire Valley Road, Oakridge, NJ 07438 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Stauffer Crematory Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 03/10/08 22. Name and Address of Facility 21. Signature of Funeral Service Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death . Part1. Enter the disease, o shock, or beart failure. List Imme e Cause (Final disease or condition resulting in death) meymonia **Physician** /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician the ! IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate I Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2[**X**No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+1 Frederick Hemen 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

			For State Registrar	State o	f Marylan		artment of I rtificate of		and M		giene Reg. No.	2008	1924
۳	<b>5</b> /15		Decedent's Name (First, Middle	e, Last)					-	2. Date of Dea	ath	_ U U U	3. Time of Death
	Physici /Medic		LEROY BENSO	N SOPER						Month MARCH	Day 8	Year 2008	12:05 A M
)	Examin		4a. Facility Name (If not institution	n, give street and nur	nber)		4b. City, Town, o	or Location o	of Death		4c. C	County of Death	
			6001 Muncaster	Mill Road	-Casey	House	Ro	ckvill	le			Montgo	mery
1	Funeral		5. Social Security Number	6. Sex 1 <b>⊠</b> M 2□ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		216-44-9558	IZIVI ZLIF	94	Yrs.				May 1			ryland
	and w		Usual Residence of Decedent  10a. State  10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	f sho	5	Md. Mc	ntgomery		Bethe	sda						1 ☐ Yes 2 X No
	the N 28a-	Director	10e. Street and Number				10f, Zip Code				10a. Citize	en of What Cou	ntry?
	with the	٥	4517 Fairfiel	d Drive			1011 2217 0000	2081	14			ted Sta	•
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status		edent Ever in U	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Orig	gin? (Spec	cify Yes or No-	- 14	4. Race - Ameri	
0	or ite		1 ☐ Never Married 2 ☐ Mar	Armed Fo ried 1 ☐ Yes	2 X No		,		i, Puerto F	Rican, etc.)		Black, White,	etc.
3	urs a al", o	ğ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	re ates:		1 ☐ Yes 2 Mo	Specify:			8	<sup>Specify:</sup> Whi	.te
2-003b	72 hc natur lical	Completed	15. Deceder	t's Education st grade completed)		16a. Dece	dent's Usual Occu kind of work done	pation	t of workin	20		d of Business/In	•
7	thin an "	츌	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retire	ed)		'9	Gove		Printing
7	ed wi	5	12	2		In	dustrial					Offi	.ce 
and	tal H d oth	Be	17. Father's Name (First, Middle,		<b>G</b>					(First, Middle, Virgin:		_	
<u>X</u>	ould Men arke	은	Robert Pero		, Sr.			Mar				Benson	
Mar	2 sh n and 1 sm raum		19a. Informant's Name/Relations				ng Address <i>(Stree</i> s						o <i>Code)</i> .ina 28677
e,	f and lealth im 27		William L. Sc	per / son						ate			
<u></u>	iges if ite or of		1 ☑ Burial 2 ☐ Cremation		State		sition (Name of matory or other pla	1				ation - City or T	
Saltimor	t. Pa tmer tant:		4 Donation 5 Other (5	· · · · · · · · · · · · · · · · · · ·	I		ville Ce		3/11	./08	Lay	tonsvil	le, Md.
ם מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee A	114/2	00 /	2. Name and Addr Muriel H	. Bark	er F	uneral	Home		2000
	40140		23a. Part1. Enter the disease, o	reamplications that o	augod the deet					-		e, Md. 2	Approximate
			shock, or heart failure. List	only one cause on e	ach line.	II. DO NOT GIN	er the mode or dy	rig, such as	cardiac of	i respiratory ar	rest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Sersi								
	Examiner	l '	The state of the s	Due to	or as a conseq		Hansh En	÷ 1,,,,,					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a conseq		Heart Fa	TTULE					
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,	be executed ician and burial-transit	Examiner	resulting in death) Last	C. Due to (	or as a conseq	uence of):							
0/00,	icate be executed physician and the burial-transit	cal		d									
8	tificate g physi as the l	늉											
Y O O	h cer endin	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come pf pregna		Testania pragnana				23	3d. Date of deliv	ery
٥	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregr	ant at time of d		∃Ectopic pregnand ☐ Other <i>(specify)</i> _	:у				Month	Day Year
5	at the by th tache	Physician/Me	9 🗆 Unknown	9□Unkno	own								
'n	The law requires that the death certifi ate has been signed by the attending i age 2 should be detached for use as	by F	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.					the cause of death?
necorus,	equin en si ould b									1 🗆 \	res 2□	No 3□Pro	bably 4 🔀 Unknown
2	law r as be 2 sh	Completed								24a. Was		24b. Were auto	opsy findings available empletion of cause of
	The atte has	E O								perfo 1 Yes	rmed? 2 X No	death?	
N I G	siction: The law certificate has birector, page 2 s	Be C	25. Was case referred to medica examiner?	1				26. Place	of Death	(Check only o			
	≥ .22 0	To E	1 ☐ Yes 2 X No	Hospital: 1 ☐ I	npatient 2	ER/Outpatier	nt 3 DCA Oti	ner: 4 □ Nu	rsing Hom	ne 5□Resio	dence 6	Other (Speci	(y) Hospice
5	ding Physician: The in.  After this certificate ha funeral director, page		27. Manner of Death 1 X Naturai 5 □ Pendir	28a. Date	of Injury th, Day Year)	28b. Time o Injury	f 28c. Inju Wo	ry at	2	8d. Describe h	now injury	occurred	
<u>Š</u>	endirath. or: A	atic	2 ☐ Accident investi	gation				]Yes 2□f	No				
IVISIOII	irector by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ined   28e. Place	of injury - At hong, etc. (Specif	ome, farm, str	eet, factory, office		2	8f. Location (S City or Tox	Street and vn, State)	Number or Rur	al Route Number,
2	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral												
	Hosp 4 hot Fune Telly fill	ical	(Check offly / 2 ☐ Medical	ng Physician: To the Examiner: On the	asis of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date an opinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) a date and p	and manner as s place, and due	stated. to the cause(s)
	thin 2 the I	Medical	one) 29b. Signature and title of certifie	and mani	ner stated.		29c. Licens						
	7 × 10 0			11. 110	ch	400		06461	5			signed (Month, rch 8,	
			grenore	www wee	wsi	mi)			<i></i>		Mai		
	6		30. Name and address of person Genevieve Wr			6001 (Type,	Print) Muncaste	er Mil	1 Roa	ad, Roc	kvil	le, Md.	20855
	Sta	to.	31. Date filed (Month, Day, Year,	32. R	egistrar's Signa								
	Sla	TC.	MAD	I A anno	. 24	<i>H</i> .	1						

			For State Registrar	State of Maryla		artment of l rtificate of		-	giene Reg. No.	2008	09242
	Physicia /Medic	_	1. Decedent's Name (First, Middle, L Howard	ast)		Shorter		2. Date of De Month March	Day	008 Year	3. Time of Death 6:55 A M
	Examin	3.40	4a. Facility Name (If not institution, g				or Location of Dea	ath	4c. (	County of Death	
10	<del>de d'aldres d'</del> a		St. Mary's Hosp  5. Social Security Number 6.		rs. last birthday	Leonar	dtown If Under 24 Hr	s. 8. Date of Bir	th	St. Mai	ry S  place (State or Foreign
	Funeral Director		214-12-9353	1 X M 2 □ F	94 Yrs.	Months Days	Hours Mir	n. October	y, Year) 12, 19	913 Mary	intrv)
-	p		Usual Residence of Decedent	100	City, Town or L	onetion.					10d. Inside City Limits
	shov shov	'n	10a. State 10b. County								1 Yes 2 □ No
	the N 28a-f notifie	Director	Maryland St. Ma	ary s	Leonar	10f. Zip Code			10g. Citiz	en of What Cou	intry?
3	3a or st be		22680 Cedar Lane Cou	rt. Apt. 1408		20650				USA	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.		Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 1	14. Race - Amer Black, White	
36	or its	by Fu	1 Never Married 2 Married	1 □ Yes 2 <b>XX</b> No If Yes, Give		1 ☐ Yes 2 🗓 No				Specify: B1	
21215-0036	illed within 7.2 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ed b	3XXVidowed 4 □ Divorced  15. Decedent's	Year or Dates:	16a. Dece	edent's Usual Occu	pation		16b. Kir	nd of Business/I	ndustry
215	in 72 in "na Medic	plet	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	e during most of w ed)				,
212	ed with giene er tha , the I	Completed	8	· · · · · · · · · · · · · · · · · · ·	Pai	nter				Govern	ment
_	0 = 0 <	Be	17. Father's Name (First, Middle, La					ame (First, Middle		Surname)	
	should be filed within 72 hours after death with the Marylan and Mental Hygiene. A show is marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	욘	Mackinley Shorte  19a, Informant's Name/Relationship		19h Mail	ing Address (Stree		Handy-Wh		Town State 7	in Code)
Ma	od 2 si Ith an 27 Isr Traur		Mynetta D. Shorter			•		ldorf, Mary			p code)
ē.	other		20a. Method of Disposition	20	b. Place of Disp	osition (Name of	1	rch <sup>Date</sup>		cation - City or	Town, State
E ,	Page ant: If ury or		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify) C	hurch Cem	etery	12,	2008		e, Maryla	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic evonce.	П	21. Sign Pare of Funeral Service Lic	censes							al Home, P.A.
_	<u> </u>		23a. Parti. Enter the disease, or co	Lardener				cown, Maryl		J65U	Approximate
٠,			shock, or heart failure. List or	ly one cause on each line.	Tv:		ing, such as card	iac or respiratory a	nest,		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	aDue to (or as a	man a language of	senne					yeurs
	Examiner		Convertible list conditions	h							(
	si g	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con-	sequence of):					6	
	xecute and al-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a con:	sequence of):					:	
58760,	death certificate be executed eattending physician and of for use as the burial-transit	dical E		d							
89	rimcate ng phy as the	Medic	15 F5144 5				10.0				
Box	eath certifi attending   I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F	etal death 3	□Ectopic pregnan	су		2	3d. Date of deli Month	very Day Year
0	at the dea by the at tached fo	/sici	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				Monar	Suy You.
<b>_</b>	Ine law requires that the tee has been signed by the sage 2 should be detached.		Part II. Other significant condition	s contributing to death but not	resulting in the	underlying cause g	iven in Part I.	23e Did	obacco u	se contribute to	the cause of death?
Vital Records,	w requires that been signed b should be deta	d by						1 103	Yes 2	□ No 3□ Pro	obably 4 Unknown
000	aw rec is bee 2 shou	Completed						24a. Was		24b. Were au	topsy findings available
		Com						perfe 1 Yes	ormed?	death?	2 □ No
/ita	clan: ertific ector,	Be (	25. Was case referred to medical examiner?	Moonitali	\			eath (Check only	one)		
0	Physical dire	은	1 Yes 2 VNo	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	2 X ER/Outpatie	SIL SO DOA		Home 5 ☐ Resi			cify)
uo :	ding h. : After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Yea		W	ork? ☐Yes 2 ☐ No	200. Describe	now injury	y occurred	
Division or	Atter	Certification:	3 Suicide 6 Could not 4 Homicide determine		At home, farm, s	treet, factory, office	е	28f. Location (	Street and	d Number or Ru	ral Route Number,
ם	ital or rs after ral Dir led in	Cent		Building, ctc. (op				J Shy of 10	mi, otale,	,	
	I o the hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, to	Medical		Physician: To the best of my caminer: On the basis of exam							
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number	0.0	29d. Dat	e signed (Monti	h, Day, Year)
	- ≯ <del>-</del> ŏ		Lam	(holly)		Do	30878	15	3	-7-08	}
7			30. Name and address of person w	no completed cause of death (	Item 23a) (Type						20619
			Dr. Daniel Howell, St			e Notch Roa	ad, Suite 2	2052, Wilde	wood (	Center, C	alifornia, MD
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland	•	irtment of tificate of		i Mental Hy	/giene Reg. No	0000	0021.3
	920	9	Decedent's Name (First, Middle, Last)	)		<del></del> -			2. Date of D	eath	4.000	3. Time of Death
•	Physicia /Medic		John	Sopous	ek				Month	10,		5:00 a M
	Examin	100	4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of De			. County of Death	
	distribution of the second	4	Asbury-Solomons					Lomons			Calvert	
I	Funeral Director		5. Social Security Number 6. Sec 483-16-1595	x 7. Age AM 2□F	(In yrs. last	t birthday) _ Yrs.	Months Days	r If Under 24 H Hours M		ay, Year,	9. Birthp Cour I Iowa	lace (State or Foreign try)
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Loc	ration				1	0d. Inside City Limits
	shov	'n	Maryland Calvert	in a series and			Julion					1 ☐ Yes 2 ☐ No
	the N 28a-f	Director	10e. Street and Number		2010	omons	10f. Zip Code			10a Cit	tizen of What Cour	
	th with 23a or 1st be	al Di	505 Aldersgate Cou	irt			2068	38		_	ted Stat	
	ems er m	Funeral	11. Manital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. V	Vas Decedent of Yes, specity Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Americ Black, White,	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	0		□Yes 213tN				Specify: Whit	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)	Ţ.	16a. Deced (Give I	ent's Usual Occ	upation e during most of v ed)	vorking	16b. K	(ind of Business/Ind	dustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	·) v			<sub>ed)</sub> t- Marke		Tex	tile Mach	ninerv
d 2	filed Hygid other ent, tl		17. Father's Name (First, Middle, Last)	4	1				lame (First, Middle			illiciy
an	ld be lental ked c	To Be	Milver Sopousek					Irene	Lenore	Jana	cek	
Maryland	shou and M s mar umat	_	19a. Informant's Name/Relationship (Ty	rpe. Print)		19b. Mailin	g Address (Stree	et and Number or	Rural Route Num	ber, City	or Town, State, Zip	Code)
Σ	and 2 alth a 1 27 k		Jan Brandstette	r		40380	Beach	Drive, M	echanics	vill	e, Maryla	and 20659
ore	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Romaval from State	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other p	ace)	Date		ocation - City or To	
Ĕ	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Specify)	inemoval from State	Brins	field	l-Echols	cre 03-	11-2008	Cha	rlotte Ha	11, MD
Baltimore,	permit. Depart Import any Inj once.		21. Sign are of speral Societies.  Edward N. Brit	of the T							neral Hom	
	452 6 6	$\dashv$	23a. Part1. Enter the disease, or compl		r.			-			town, MD	20650 Approximate
k			shock, or heart failure. List only of	ne cause on each line	Э.			-	nac or respiratory	arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Covebra  Due to (or as a	CONSEGUE	oce of):	ricciel to	1				
	Examiner			Horite								
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	ecutec nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Chimic	050ナ	Netiv	t Polmo	ay Dire	116			
60,	ifficate be executed g physician and as the burial-transit	Ĕ	resulting in death) Last	Due to (or as a	consequer	nce of):						
68760,	cate b	edical		d								
	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnanc	У					23d. Date of delive	PLA
Box	death certi	Physician/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal de	eath 3 🗌	Ectopic pregnar Other (specify)	су			Month	Day Year
oj.	t the cay the achec	hysi	9 Unknown	9□Unknown								
S, P	law requires that the death cert as been signed by the attendin 2 should be detached for use	by P	Part II. Other significant conditions co	ntributing to death but	t not resultir	ng in the un	iderlying cause g	iven in Part I.		/	use contribute to the	
ord	w requir been si should I	ted							- 1	Yes 2	Pot 3 Prob	pably 4 □Unknown
or Vital Records,	law law las be	Completed							24a. Wa	opsy	prior to co	psy findings available mpletion of cause of
E E	: The cate had page	Co							per 1∐ Yes	fórmed? ∑Z No	death? 1 ☐ Yes	212No
Zi Zi	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			_ [0	Ab	Death (Check only			
0	Phys r this ral dir	2	1 Yes 2 No	1 ☐ Inpatien		NOutpatient  Bb. Time of	1 3 DOA	4 Nursing	g Home 5 Res		6 ☐Other (Specif	y)
o	Attending Physician: r death. ector. After this certific: by the funeral director,	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	W	ork? □Yes 2□No	200. Describe	z now myc	ny occurred	
Division	Atter r deal ector by the	ifica	3 Suicide 6 Could not be determined	28e. Place of injur	ry - At home	e, farm, stre	eet, factory, offic	е	28f. Location	(Street a	nd Number or Rura	al Route Number,
ā	tal or / s after al Dire ed in b	Cert	4 Hornicue	building, etc.	. (Specify)				City or 10	own, Stat	θ)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exami	sician: To the best of iner: On the basis of and manner state	examination	edge, death n and/or inv	occurred at the restigation, in m	time, date and play opinion, death o	ace, and due to th ccurred at the time	e cause(s e, date ar	s) and manner as s nd place, and due to	tated. o the cause(s)
	To th Within To th Comp	Me	29b. Signature and title of certifier	^ ^			29c. Lice	nse number			ate signed (Month,	
			1 Dond y	Todo me	0		0	17510		Ma	vd 10,	2008
	100		30. Name and address of person who co									
	101		David Tardio, M.D				ve, Pri	ice Frede	erick, Ma	ary1a	and 20678	
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Peristrar	s Signatur	& A	Soule !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 **Physician** March 5, Arthur Lee Tippins, Jr. 10:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 577-30-4948 29. Florida 1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2X No **Funeral Director** Calvert County Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2804 McDuff Drive items 23a 20732 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 if Yes, Give 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify. Specify: White ģ 3 ₩ Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck Driver Truck Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Lee Tippins, Sr. Stella Krembton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 McDuff Drive, Chespeake Beach, MD 20732 Kevin M. Tippins (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Marchate 12. permit. Pages 1
Department of H
Important: If Ite
any Injury or oti
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vets. Cemtery 2008 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of 8125 Southern Maryland Blvd., Owings, MD 20732 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 'YOS take Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Directo for as a consequence of: O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 20 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No 1 Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Anatural 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled is ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number

State Registrar

29d. Date signed (Month, Day, Year)

Parul S. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jani, M.D

31. Date filed (Month, Day 32. Registras Signature 2008

Division or Vital Records, P.O. Box 68760,

State

31. Date filed (Month, Day, Year) MAR 1 0 2008

29b. Signature and title of ogrtifier

30. Name and address of person who completed cause of death (Item 23a) (Tyre, Print)

Registrar

29c. License number

eenway Ctr. DA Greenbelt Med 20210

State of Maryland / Department of Health and Mental Hygien

09246

						Certific	ate of	Death	,	Reg. No.		g	1 ()
			1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ıth		3. Time of D	)eath
	Physic /Medi		Lucy Pearl	Vaughan					Month March	Day 10, 20	Year 008	7:50 a	a.m.
	Exami		4a. Facility Name (If not institution, given					4b. City, Town, or Lo			inty of Death	7.30 6	4 4 111 4
			Bayside Care Ce	nter				Lexington	Park	St.	Mary's		
	Funeral			Sex 7. Age (In yrs.	last birtl	hday) If Ur Mont	der 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day			place (State or F	Foreign
	Director		202-14-9655 Usual Residence of Decedent	1□ M 2X F 84	· Y	rs.	Days	riours Will.	01/30/	1924		ylvania	
	yland pow		10a. State 10b. County	10c. Ci	ty, Town	or Location					1	0d. Inside City	Limits
	Mar	ţō	Maryland St. Mar	v's Gre	at N	4ills						1 ☐ Yes 2	X No
	h the	Director	10e. Street and Number				Zip Code			I0g. Citizen	of What Cour	itry?	
	h wit	a D	45502 Westmeath W	av		20	0634		I	Inited	State	S	
	deal	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I,S.			Hispanic Origin? (Spo an, Mexican, Puerto		14. 1	Race - Americ	an Indian,	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other treumette event, the Medical Examiner must be notified at once.	5	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				Specify:	Hican, etc.)		Black, White, ec <i>ify:</i> זגז	<sub>etc.</sub> nite	
9	72 ho	Completed	15. Decedent's E	ducation	16a. [	Decedent's U	Isual Occu	pation		16b. Kind o	f Business/Inc		
7	thin 7	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(	life. DO NO	work done T use retire	during most of works d)	ng				
7	gience grafter	Й	12	0011090 (1 401 01)	Hon	nemake	r			Own H	lome		
9	e file al Hy othe vent	Be C	17. Father's Name (First, Middle, Last,					18. Mother's Name	(First, Middle,				
<u>a</u>	uld b Venta rked ritic e	To	Adam Bonieckie					Mary Thor	nkulska				
Maryland	sho and l sma sums		19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Addr	ess (Street	and Number or Rura	I Route Number	, City or To	wn, State, Zip	Code)	
Σ.	and 2		Michael E. Vaugha	n/Son	470	)17 Pi	per C	ourt, Lexi	ington H	Park.	MD 20	653	
ore	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	20b. F	Place of I	Disposition (i	Name of or other pla	ce)			on - City or To	wn, State	
<u>Ĕ</u>	Pag nent int: if		4 □ Donation 5 □ Other (Specif	Themoval from State	-127	o Nat		1	/18/08	Triand	710 V	irainia	
Baltimore,	mit. partr ports y inj		21. Signature of Funeral Service Licer	ISBR /	-			ss of Facility					
В	8 9 E E 8	0.0	Kyle S. Simons	M01206	un	22055	U <sub>0</sub> 11	Brı ywood Roaي	nsfield			•	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		h. Do no						VII, MID	20650 Approximate Interval Between	
Y	Physician		SHOCK, OF HEART FAILURE. LIST OTHY	one cause on each line.	/						į	Onset and Dea	en ath
E.	/Medical		Immediate Cause (Final disease or condition	ATI	126	/ En	hal	5,01				Mont	16
	Examiner		resulting in death)	a. Due to (c	or as a co	onsequence of		2)   0. (				1-10/17/	13
	₽ #	Examiner	_	HYI	Sels	PASIO	21					V	
	and trans	(am	Sequentially list conditions, if any, leading to immediate	Due to (c	rasaco	nsequence o	of):						
8	clan sourial	<u>E</u>	cause. Enter Underlying Cause (Disease or injury	•							1		
68760,	cate I	<u>ë</u>	that initiated events resulting in death) Last	Due to (o	r as a co	nsequence o	f):					· · · ·	
S S	certificate be executed ding physician and se as the bunal-transit	/Medical		d									
				<b>U</b> .									
o	the shed	Physicia	Part II. Othar significant conditions of	ontributing to death but not resi	ulting in t	he underlying	g cause giv	en in Part I.	23b. Did to	bacco usa	contributa to	tha causa of d	Jeath?
л О	The law requires that the death ite has been signed by the atten page 2 should be detached for u								1 □ Y	s 2 N	o 3□ Prob	ably 4 ☐ Uni	known
Vital Records,		d b							040 14/00 0		Odb Wo	ro autonou find	lines
ਨ੍ਹ	w require been si should l	Completed							24a. Was a perforr	n autopsy ned?	ava	re autopsy findi ilable prior to npletion of caus	•
ĕ	e law	줱									of d	leath?	
									1 □ Y∈	s 2⊠No	1 🗆	Yes 2□ No	)
		•	25. Was case referred to medical examiner?	Haspital			011	26. Place of Death		•			
5	si si	2	10 163 20 160		ER/Outp			4 L Nursing Hon				)	
	ding F h. After funer	5	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	ıry	28c. Injur Wor		8d. Describe ho	w injury occ	urred		
<u>s</u>	death death ttor:	<u>ड</u>	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OSo Place of leiver. At he		M		Yes 2□No	Of Leastine (Or			Douba Mumba	
DIVISION	al or Attending F s after death. I Director: After d in by the funer	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		i, street, racto	огу, опісе	2	8f. Location (St. City or Town	, State)	inder of Aurai	Houle Number,	,
	ospita hours inerel ly fille		29a. Certifier 1 Cartifying Phy	sicien: To the best of my know	wledge, d	death occurre	d at the tin	ne, date and place, a	nd due to the ca	use(s) and	manner as sta	ated.	
	To the Hospital of within 24 hours a To the Funerel D completely filled	edical	(Check only 2 Medical Exam	iner: On the basis of examinat and manner stated.	ion and/o	or investigation	on, in my o	pinion, death occurre	d at the time, da	ite and plac	e, and due to	the cause(s)	
1	Veit Con	Σ	29b. Signature and title of certifier	\		2	9c. Licens	- 0			ned (Month, D		
			P N- COM	7.			114	1978		3-1	-20	10	
	-		30. Name and address of person who o	ompleted cause of death (Item	23a) (Ty	(pe, Print)	/ I) a	01 +43	12 8	ivie	M	20711	6
		_	31 Date filed (March Don Vaca)			ch,)10	1116	10	100	, , , , , , , , , , , , , , , , , , , ,	مب	- 110	/
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure								

DHMH 16 Rev 6/95

	1	or State Registrar			of Mary	yland		artmen rtificat				lental Hy	giene	20	08	09	247
Physician	1. De	cedent's Name	(First, Middi			***	T T T A 1	40				2. Date of Do Month	Day		Year	3. Time o	
Medical kaminer	4a. Fa	cility Name (If	not institutio	n, give street and i ELINE D	number) RIVE	MT	LLIA	4b. City,	Town, or	Location o		FEBRUA			ty of Death		<b>A</b> M
neral ector	57	7-42-2	193	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (Ir	n yrs. last 75	birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi	th 1932		9. Birth	place (State intry) HINGT	or Foreign ON DC
Ď	10a. S		10b. County		10		own or Lo	cation HIL	J.S							10d. Inside (	City Limits
I Director		Street and Num		LINE DR	TIZE			10f. Zip	Code	0744			_		f What Cou	intry?	
t by Funeral	11. M	arital Status  Never Marrie	d 2 Mar	12. Was Do	EVE ecedent Eve Forces? s 2 ☐ No Give r Dates:	195 195	5	Was Deced f Yes, spec		spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or Ne Rican, etc.)		14. Ra	ace - Ameri ack, White,		
Be Completed	Ele	(Specil mentary/Secon 12	y only highe	t's Education st grade complete College	d) e (1-4or 5+)	1	6a. Deced (Give life. I	tent's Usua kind of wor DO NOT us RK	il Occupa rk done d se retired,	ition luring most	t of worki	ng			Business/In		RVICE
Be	E	ther's Name (F	WILL:	IAMS							MZ	(First, Middle	NT		·		
y or other traumatic	AN 20a. M	GELIQU Method of Dispo Marial 2	E HII	hip (Type, Print) NES/NIE  3 □Removal fro	2	20b. Place	1271 e of Dispo		NNY ne of ther place	CT.	UPE	PER MA	.RLB( 20c. Lo	ORC cation	MD - City or To	2077	4
any injury or o	-	Donation signature of Fun			<del>d</del> -		22	. Name an	d Addres	s of Facility	STF	CICKLA D. CA	ND F	TUE	ERAL	SER	VICES
cian dical	Imme	Part1. Ent shock, or heart ediate Cause (F se or condition ting in death)		a	REBROV	ASCU	LAR A			g, such as	cardiac o	r respiratory a	rrest,			Approxima Interval Be Onset and	tween
hysician and the burial-transif	triat ir	leading to imm Leading to imm Enter Under g (Disease or in itiated events ing in death) La		b. DIA	ABETES to (or as a co PERTENS to (or as a co	MELI onsequent SION	LITUS ce of):					_					
be detached for use as by Physician/Mec	23b. \	MALE: Was decedent   n the past 12 m   Yes 2     Unknown	onths?	1 Live	outcome of positions of positio	Fetal dea	ath 3	Ectopic pre					2		ate of deliver	ery Day	Year
	Part II	Other signific	ant condition	ens contributing to	death but no	ot resultin	g in the ur	nderlying ca	iuse give	n in Part I.						he cause of	
e Completed	25 W	as case referre	d to medical								_	1 ☐ Yes	psy ormed? 2 X No	24b.	prior to co death?	opsy findings ompletion of	available cause of
To B	ех	aminer?		Hospital:	Inpatient	2□ER/	Outpatien	3 □ DO	A Othe	-		<i>(Check only o</i> ne 5 <b>K</b> Resi		. □Ot	her (Specif	fv)	
unera On:	1 ( 2 l	Natural Accident	5 Pendin investig	ation	e of Injury onth, Day Ye		b. Time of Injury		Bc. Injury Work		2	8d. Describe				,,	:
rai Director: /		Suicide Homicide	6 Could r	ined 286. Pla	ce of Injury - Iding, etc. (S	ipecify)						8f. Location ( City or To	wn, State)				nber,
completely filled Medical Ce		one)	Medical	g Physician: To t Examiner: On the and ma	he best of my basis of exa anner stated.	ımınatıon	dge, death and/or inv	estigation,	in my op	inion, deat	d place, a	ind due to the ed at the time,	date and	place	, and due to	o the cause(	s)
Con		Signature and ti	Nif F	? 1/2		Mis	2.	ME	License							Day, Year) 2008	
1	30. Na <b>MI</b>	me and addres	s of person VILI	who completed ca	M.D.,	(Item 23a	a) (Type, I C 50	Print)	ig st	REET	NW,	WASHIN	IGTON	,DC	2042	22/688	
State Registrar		te filed (Month		32.	Registrar's S	Signature	2										

Baltimore, Maryland 21215-0036 **Physician** Examiner Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK, Adeeb aro Jaber 100 HOSPITAL 31. Date filed (Month, Day, Year) 32. Registra State 2008 Registrar DHMH 17 Rev 1/2001 ORIGINAL

	1 - State Registrar	Certificate of Death	Reg. No. 2000 0021. 0
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 1, 2008 Year 2:05 A. M
/Medical	Walter Arthur Wieman, Jr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
Examiner	Solomons Nursing Center	Solomons	Calvert
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. In 17. Age (In yrs. In yrs. In 17. Age (In yrs. In  st birthday) Yrs.  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.	9. Birthplace (State or Foreign Country) New Jersey	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10a. State  MD  Calvert  10c. City,  MD  Calvert  Lus  10e. Street and Number  326 Coyote Trail  11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)  Walter Arthur Wieman, Sr.  19a. Informant's Name/Relationship (Type, Print)	10f. Zip Code 20657  13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto Vietnam Yes 2 No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Contract Negotiator  18. Mother's Nam Elizabe	Specify: White  16b. Kind of Business/Industry  US Government  Be (First, Middle, Maiden Surname)  th Pitkin  Tal Route Number, City or Town, State, Zip Code)
Baltimore, IM bernit. Pages 1 and 2 bepartment of Health mportant: If item 27 i nny injury or other tra once.	1□ Buriel 0 M Cremetics 0 □ Bernouel from State	326 Coyote Trail, Lus ace of Disposition (Name of metery, crematory or other place) tomy Gifts Registry 3/	Date 20c. Location - City or Town, State
Baltimo permit. Page Department of Important: If any injury or once.	21. Signature of Funeral Service Licenses	1	ausch Funeral Home, P.A. usby, Maryland 20657
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a		or respiratory arrest,  Approximate Interval Between Onset and Death
certificate be executed executed continuing physician and se as the burial-transit and continuing the continuin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen	ance of):	Ye213
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of decent programmes and the pregnant at time of decent programmes and the pregnant at time of decent programmes and the pregnant at time of decent programmes and the pregnant at time of decent programmes and the pregnant at time of decent pregnant at time	death 3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
<u>- 교 호 및 L</u>	Tak II. Other algitime and conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
			24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
VITCS SICIAN CERTIFICATION OF BE	25. Was case referred to medical examiner?	Othor	th (Check only one)
DIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I  Medical Certification: To Be C	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	R/Outpatient 3 □ DOA	ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number.
DIV vital or A urs after ral Direct lied in by Certif	4 Homicide determined building, etc. (Specify)		City or Town, State)
o the Hosp ithin 24 hou o the Fune ompletely fi	and manner stated.	on and/or investigation, in my opinion, death occu	rred at the time, date and place, and due to the cause(s)
To with	29b. Signature and title of certifier	29c. License number 34188	29d. Date signed (Month, Day, Year)  March 4, 2008
w 6+1	30. Name and address of person who completed cause of death (Item 2 David Federle, MD 24035 Three No.	23a) (Type, Print) otch Road, Hollywood, I	Maryland 20636
State Registrar	31. Date filed (Month, Day, Year)  MAR - 4 2008	H. Sparks	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day MARCH JOHN. WARFIELD, 6 12:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20800 WOODFIELD ROAD GAITHERSBURG MONTGOMERY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth Jan. 2, 1941 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2□ F 577 54 1124 67 Washington, D.C Yrs Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-1 show traumatic event, the Medical Examinar must be notified at Md. Montgomery Gaithersburg 1 ☐ Yes 2 No Director the 10e. Street and Number 10f Zin Code 10α. Citizen of What Country? 5 20800 Woodfield Road or items 23a 20882 death United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If thes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene important; if Itam 27 is marked other than "naturel, or its may injury or other traumatic event, the Medical Examina and. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Roofing Company Owner - Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John T. Warfield, Sr. Anna Grace Besley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Michelle B. Simonds, Daughter 20800 Woodfield Road, Gaithersburg, Md. 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Neelsville Cemetery 3/15/08 Germantown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home N . muriel P.O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) **Physician** carcinoma of Unknown primary Metastatic /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physicien and I be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? autopsy performed; 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 43083 March 7, 2008 mon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George A. Sotos, M.D. 9707 Medical Center Drive, #300, Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 0 2008 Registrar

		1 = For State Registrar	State of Mar	-	epartment of F Certificate of		•	giene Reg. No. 00	8 09251
¥		Decedent's Name (First, Middle,	Last)				2. Date of De	ath	3. Time of Death
Physici /Media		Bernard	Lee	Weimer	r		March	7, 2008	4:00 a M
Examir		4a. Fecility Name (If not institution,	•		4b. City, Town, o	r Location of Death		4c. County of	
		Charlotte Hall	Veterans Hom	e		otte Hall		St	. Mary's
uneral			άζην ο□E	In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	<ol> <li>Birthplace (State or Foreign Country)</li> </ol>
irector		212-24-2022 Usual Residence of Decedent	75111 201	80 Yrs	5.		Aug. 1	9,1927	Maryland
<b>*</b>		10a. State 10b. County	1	Oc. City, Town o	r Location				10d. Inside City Limits
Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be inclifted at once.	ō	Maryland St.	Mary's	Ch	arlotte Hal	11			1 ☐ Yes 21 No
28a	Director	10e. Street and Number	Haly S	CII	10f. Zip Code	L.L		10g. Citizen of Wh	eat Country?
3a or		37785 Mohawk D	rive		206	522		US	
me 2	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H		pecify Yes or No		American Indian,
른曹		1 Never Married 2 Marrie	Armed Forces?		_		o Rican, etc.)		White, etc.
- 3	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2€50No	Specify:		Specify:	White
lica li	Completed	15. Decedent's (Specify only highest		16a. D	ecedent's Usual Occup	pation	kina	16b. Kind of Busi	ness/Industry
	du	Elementary/Secondary (0-12)	College (1-4or 5+)	`iii	fe. DO NOT use retired	d) _	9		
크	S		4		State Troo	1			State Police
p 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Be	17. Father's Name (First, Middle, L.	•	7 - 4		_		, Maiden Sumame)	
nark natic	은			Weimer		Rosa			Warnick
n er	1	19a. Informant's Name/Relationshi			lailing Address (Street			-	
E Per		Virginia L. Wei  20a. Method of Disposition			785 Mohawk	Drive, C	Date	20c. Location - C	
0 0		1 ₺ Burial 2 ☐ Cremation		cemetery,	crematory or other plac	ce)	Date	20c. Location - C	ity or Town, State
dury		4 □Donation 5 □ Other (Sp		St. Mar	y's Cemete	ry   3/1:	1/2008	Bryantow	n, Maryland
mpoi any Ir		21. Signature of Funeral Service	census III		22. Name and Addre	ss of Facility  -Echols	Funeral	Home, P.	A a11, MD 20622
= 6 G		1 deple		1817					
		23a. Part1. Enter the disease, or o shock, or heart failure. List o	nly one cause on each line.	e death. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
ician		Immediate Cause (Final disease or condition	_ Pneur	noni	a				Onset and Death
dical niner		resulting in death)	Due to (or as a c	onsequence of):					
	_	Sequentially list conditions,	b Dys Y	ohas	ra				
sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	Due to (crasa)	onsequence of		<b>^</b> - · ·	J . L	Jakel	
-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of	cular	ACCI	cent	hist	my
pnysicien and s the burial-transit		,	C	onsequence or).	Oda	dian			J
the	dlcal		d. LOYDY	MUN	I II TENU	Chize	ase		
should be detached for use as	an/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy			nite detice	45.0	4.14
for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 [	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	1		23d. Date Monti	
peyo	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ie oi deatti	J Uner (specify)				
deta		Part II. Other significant condition	s contributing to death but r	not resulting in th	ne underiving cause giv	ren in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
d b	d by	hunerten s	mis		, ,		112	Yes 2 □ No 3	Probably 4 Unknown
shoul	Completed	1 About	011.110	Land			04-146	are w	
9 2	E G	- HITIM	FIBRILLO	C11010			24a. Was	osy o pri	ere autopsy findings available or to completion of cause of ath?
r, pag		hyperl	ipidemi	a			1 ☐ Yes	280 No 1E	Yes 2□ No
recto	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea			
ig ig	၉	1 ☐ Yes 2 ☐ No 27. Manner → Death	1 ☐ Inpatient	2 ER/Outpa	Itient 3L DOA	4 Nursing H		dence 6 Other	
fune	ilon:	1 ☐Natural 5 ☐ Pending	(Month, Day Y	ear) 200. Till	ry Wor	k? Yes 2 □ No	20g. Describe	now injury occurred	•
the	cat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	ot be 300 Blace of laive	. At home, form	, street, factory, office	163 2 110	28f Location /	Street and Number	or Rural Route Number,
i Q	CertIf	4 Homicide determin	building, etc. (		, street, ractory, office		City or To		or ribrar rioute realider,
t liled	a C	29a, Certifier 1 Certifying	Physician: To the best of r	ny knowledge d	leath occurred at the fu	me date and place	and due to the	cause(s) and man	nor as stated
to the Funerel Director: Aller this certificate has completely filled in by the funeral director, page 2.	edlo	(Check only 2 ☐ Medical E	xaminer: On the basis of ex and manner stated	camination and/c	or investigation, in my o	pinion, death occu	rred at the time,	date and place, an	d due to the cause(s)
ото	Me	29b. Signature and title of certifier	01		29c. Licens	e number		29d. Date signed (	(Month, Dey, Year)
- 0		DPC	Still	, · L	WDU	5092		3/7/	7008
		30. Name and address of person w	ho completed cause of deat	th (Item 23a) (Tv		3012		2111	2008 L, MD206;
	1 3	110 Hospita	1 Road	Sui	te 205	Princ	e Fr	edent	6. MD206
Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1000	1	<u> </u>	0.0-10	- 1.00

DHMH 17 Rev 1/2001

State

Registrar

MAR 1 0 2008

			1 - State of Registrar	Maryland / Depa Ce	artment of F <i>rtificate of</i>			ne No.2 A A R	09252	
	Physici	an	Decedent's Name (First, Middle, Last)  Edward George Winnicki				2. Date of Death Month Day Year March 11, 2008			
	/Medio		4a. Facility Name (If not institution, give street and number) 4b.			c. City, Town, or Location of Death		rch 11, 2008 11:30 A M		
			St. Mary's Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)		Leonardtown If Under 1 Year   If Under 24 Hrs.   8		8. Date of Birth	St. Mary s		
Jan S	Funeral Director		376-03-9452 <sup>1</sup> <b>™</b> <sup>2</sup> □ F	<b>89</b> Yrs.	Months Days	Hours Min.	(Month, Day, Ye January 16		nplace (State or Foreign untry) <b>chigan</b>	
0.00	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits	
			Maryland St. Mary's		Leonardtown			1 <b>⊠</b> Yes 2 □ No		
			10e. Street and Number  22810 Dorsey Street Apt. 311		10f. Zip Code <b>20650</b>		10g.	10g. Citizen of What Country?  USA		
Baltimore, Maryland 21215-0036			11. Marital Status 12. Was Deced Armed Forc	! 🗆 No	U.S.   13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric  1 □ Yes 2 No Specify:  16a. Decedent's Usual Occupation					
			3 Widowed 4 Divorced If Yes, Give Year or Date	es:				Specify: White  16b. Kind of Business/Industry		
			15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	kind of work done during most of working DO NOT use retired) taker		Se	Senior Apartment Housing			
			17. Father's Name (First, Middle, Last)  Juzef Winnicki		18. Mother's Name (First, Middle, Maiden Surname)  Lucyja Jarkoska					
			19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					ip Code)		
			Lucille A. Koranek / Daug 20a. Method of Disposition	20b. Place of Dispo			Date 20	c. Location - City or	Fown, State	
			1 ☐ Burial 2 【A Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate	an Cremator	Harch	·	lexandria, V	/irginia	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licenses  Mckall Garcle	ner) 2	2. Name and Addre Mattingley P.O. Box 2	-Gardiner F	uneral Home town, MD 200	P.A. 650		
3	Physician /Medical Examiner	Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Account Accou							
1			resulting in death)  Due to (or as a consequence of):						70465	
ā			if any leading to immediate	ras a conseduence off.	consequence of:  Townsol  Town			nouls		
	ecuted ind transit		Cause (Disease or injury that initiated events C.	) ehy doa						
	cate be executed physician and the burial-transit		d	Piowhol						
	at the death certifi by the attending tached for use as		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery  Month Day Year			
	es tha gned be de		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  (2) abetes mellims.				23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should						24a. Was an autopsy findings available prior to completion of cause of			
							performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No			
			25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Ing	nt 3 DOA Oth	26. Place of Death (Check only one)  Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify)					
			27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month,		28c. Injury at Work?		28d. Describe how injury occurred			
			2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fa building, etc. (Specify)			M 1 1 Yes 2 No , factory, office 28f. Loc. City		ation (Street and Number or Rural Route Number, or Town, State)		
			29a. Certifler (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifler (Check only one)  1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
			and married states.			29c. License number		29d. Date signed (Month, Day, Year)		
						D61719		03/14/2008		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhananjay Bhavsar, M.D.  24035 Three Notch Road Hollywood, MD 20636							
	Sta Registr			gistrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month 3 **Physician** : 40 PM 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lin tusol enera Norceste HTlant If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (În yrs. last birthday) **Funeral** Days 1⊠M 2□F Hours 89 221-05-3307 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other trsumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10305 Cathell Rd. 21811 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Owner/Operator Gas Station permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any lighty or other traumatic event, spice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada Mitchell George T. Wainwright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Graison Wainwright / son 10304 Cathell Rd., Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/10/2008 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Serratia **Physician** Marcescons /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physicien and be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed noni CV Due to (or as a consequence of) Box 68760, Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coninbule to the cause of death? Records, 3307 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No 1☐ Yes Vital within 24 hours after death.

To the Funers! Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 No 1- Impatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ð 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral L to the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b Signature 29c. License number

BAYFI

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1919

3/07/

DOB

E. Wainwight

State S Registrar

31. Date filed (Month, Day, Year)

MAR 1 0 2008

32. Aggislrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Physician Claribel Bradley Windsor 6, 9:35A M March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot William Hill Gardens Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 □ M 2 □KF 82 220-16-9689 Director May 6, 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1X Yes 2 No MD Director Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 103 Thompson Street 21643 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√□XNo Specify White 3 ₩ Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlton Goldsborough Bradley Katherine Harper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ross B. Windsor/Son 300 Dolley Madison Rd., Greensboro, NC 27410 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 MBurial 2 □ Cremation 3 □ Removal from State Unity-Washington Cem. 03/09/08 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sexento resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) I∐Yes 2. No the 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No

Division or Vital Records, P.O. Box 68760, After this certificate the Hospital or Attending Physician: after death, within 24 hours a To the Funeral I

> State Registrar

DHMH 17 Rev 1/2001

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Certification:

င္ပ

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Momicide

29b. Signature and title of contifier

William

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wood

5 Pending investigation

6 ☐ Could not be

determined

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

Lane

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21601

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			Please	Type or Print in E				•	_	
			1 State	State of Marylan				lental Hygi	ene nna	09255
	_		Registrar	***	Cei	rtificate of	Death		g. No.	2 Time of Doort
	Physici /Medio		1. Decedent's Name (First, Middle, Las Edna Evelyn Ada	·	ton			2. Date of Death Month March	Day Year 6, 2008	3. Time of Death 12:45 p M
	Examin	er	4e. Fecility Name (If not institution, give				or Location of Death		4c. County of Dee	
			Chesapeake Woo		h a biab da d	Cambri		O Date of Bigh	Dorche	
	Funeral Director		210-10-9034	9x 7. Age (In yrs. I		Months Days	Hours Min.	8. Date of Birth (Month, Day Jan. 22	,1914 Ma	thplace (State or Foreign ountry) ryland
	and w		Usuel Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show digel Examinan most be notified at	tor	MD Dorche	ster		Сал	nbridge			1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	th wit	ai D	525 Glenburn	Avenue			21613	U	nited St	ates
	ems erms	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am- Black, Whi	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specity:	Black
Ö	hour tural		3€ Widowed 4 Divorced  15. Decedent's Ed	Year or Dates:	16a Daga	dest's Henri Conus	etico		6b. Kind of Business	Andresta
15	in 72 n na ledic	Completed	(Specify only highest gra-	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work d)	ing	60. Kind of Business	vindustry
212	with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	-	stic Wo			Private	Homes
שַ	e filec Il Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
/lar	uld b Venta vrked rtic e	To E	Thomas E. Adam	Pinkett	Adams					
Maryland 21215-0036	and and is ma		19a. Informant's Name/Relationship (7	**	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)
≥,	and ealth m 27 her tr		Bonny Nichols/						k, MD 21	
altimore,	t of H If its or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	sition (Name of natory or other place	ce)		Oc. Location - City or	
Ë	t. Pe ntmen ntant: njury		*4 □ Donation 5 □ Other (Specify	·		e Cremato L Name and Addre	- 1	(	Cambridge,	Maryland
Bal	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show eny injury or other traumatic event, it a Medical Examinar must be notified at 2008.		21. Signature of Funeral Service Licen	ramptom F 1632	Tuneral Ho	me				
北	ráb		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the death one cause on each line.	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Septice	mia,	general	lized			Onset and Death
п	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	1.11.	100011	L . Ot	d small bonal	2
64	2	<u></u>	Sequentially list conditions,	b. Ventral k	emit	with me	M. CMUER, S	1 ranguestes	Smill bonol	days
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	230 (0) (0) (3) (2 00) (30)	101100 OI).					
Ć.	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	c	ience of):					
760,	The law requires that the death certificate be executed the has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	<u>a</u>		d						
89	eath certificate attending phy: I for use as the	Medi	re estate							
Вох	th certendir	an/N	230. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetel		Ectopic pregnancy	,		23d. Date of de	
П	that the death cer ed by the attendir detached for use	Physician/Medic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of de 9☐ Unknown		Other (specify)			Month	Day Year
P.O.	hat th	Ph)	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the u	adarhina causa aw	on in Part I	23a Did toba	acco use contribute t	o the cause of death?
Division of Vital Records,	w requires that been signed to should be deta	d by	Dementia	onthousing to death but not resu	stang in the di	radilying cause giv	en in raiti.		2 □ No 3 □ P	_
Ö	v requ	ete						24a. Was an		
Rec	he lav	Completed						autopsy perform	prior to	utopsy findings available completion of cause of
a	ticien: Th certificate rector, pag	e C	25. Was case referred to medical				OF Place of Deet	1 Yes 2		s 2□ No
>	Attending Physician: r death. sector: After this certifies by the funeral director,	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA Oth			ice 6 Other (Spe	rcify)
0	ding Phys	n: H	27. Manner of Death		28b. Time of			28d. Describe hov		
Ö	andin ath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation		,ury		Yes 2□No			
$\leq$	or Attendated after death Director:	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	urs af	OL		ļ						
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier  (Check only one)  1 ☑ Certifying Phy 2 ☐ Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the ting estigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dal	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To t Withi To tl	Σ	29b. Signature and title of certifier	1/10 )		29c. Licens	e number	29	d. Date signed (Mon	th. Dey, Year)
			<u> </u>	MILLONIA	1, MD		VZ592	7	3.7.0	8
			30. Name and address of person who completes	completed cause of death (Item	23a) (Type.	Print) Sum un s	Lane, L	Easton,	Date signed (Moning of the Company)  MD Z	1601
2	Sta Registra	_	31. Date filed (Montante Year)	008 32. Pigistrar's Signat	шгө	Conto				
				2	7257					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per 16 881 7-31-08 to State of Maryland Department of Health and Mental Hygiene 0 8

0	9	2	5	6

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Kendall 7:30 Lynne Wells February 23. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Nursing & Rehabilitation Denton Caroline If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 213-44-0974 **Funeral** 1 ☐ M 2 ☑ F 68 Director December 14, 1939 New Jersey Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Greenshoro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9 108 South Main Street or items 23a 21639 United States of America death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 [½]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ģ 3 Widowed 4 Divorced Caucasian 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene None None permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 Is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Joseph Girand Conneely Kathryn Virginia Kendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn V. Conneely Mother 26324 Hobbs Road, Denton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Capitol Crematory 2/28/2008 Dover, Delaware 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signature of Funeral Service License audes 100K 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Denton, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exar iner Sit To the Hospital or Attending Physician: The law requires that the death certificate be execuled physician and s the burial-trans Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical as IF FEMALE 1150 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Medical Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 Tes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number S 20047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market Str. Walik Zaki, M.D., Market Street, Denton, Maryland 21629 State Registrar

AS 1 DHMH 17 Rev 1/2001

		State of State of Registrar	Maryland / Do		tment of H			giene Reg. No.?	กกล	ng	257
Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	-	2008		of Death
/Medic	al	Robert Morgan Yoder  4a. Facility Name (If not institution, give street and num	ber)		4b. City, Town, or	Location of Death	March		nty of Death	4:14	P M
	4	Frederick Memorial Hos	pital 7. Age (In yrs. last birth	nday)	Frederic	k If Under 24 Hrs.	8. Date of Birt		derick		e or Foreign
Funeral Director	93	196-20-5277 1X M 2□F		rs.	Months Days	Hours Min.	JAN. 14	v. Year)	Cour	sylva	
/land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Loc	ation				1	0d. Inside	City Limits
ne Mary 8a-f sh otified	Director	Maryland Frederick	Fre	der				10- China	of Milest Cour		es 2 □ No
with the 3a or 2		10e. Street and Number 1715 W. 7th St.			10f. Zip Code 21702				g. Citizen of What Country? Inited States		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married If Yes Gives If Yes Gives	2 □ No		as Decedent of His Yes, specify Cubar ☑ Yes 2 <b>K</b> No		pecify Yes or No o Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.	
2 hours		3 M Widowed 4 □ Divorced Year or Da  15. Decedent's Education (Specify only highest grade completed)	tes: WW II	Decede	ent's Usual Occupa	ation	king		f Business/In		
within 7	Completed	Elementary/Secondary (0-12) College (1	4or 5+)		ind of work done do NOT use retired; Petty Of		ning .	U.S.	Navv		
e filed value other vent, th	Be Co	17. Father's Name (First, Middle, Last)		LUL	Tetty of	18. Mother's Nan	ne (First, Middle,				
y can	To	Albert S. Yoder  19a. Informant's Name/Relationship (Type. Print)	10h	Mailing	Address (Street a	Beatri			rgan	Code)	
ind 2 st alth and 27 is n		Stephen E. Yoser / Son		_	/ilowbroo					023	
permit. Pages 1 and 2 should be filed within Department of Health and Menta Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee.		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Removal from 9	state		ition (Name of atory or other place	1	Date		on - City or To	own, State	
nit. Parartmen artmen ortant: Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Greenwo		Cemetery Name and Addres			Atlant Funera			
Dermii Depar Impor any In		Baymond Bele	rson	16	21 Oposs	umtown P	ike/Fred	derick		21702	
		23a. Part1. For the disease, or complications that control shock of heart failure. List only one cause on example immediate cause (Final	ich line.			g, such as cardiad	or respiratory a	rrest,		Approxim Interval E Onset an	nate Between nd Death
Physician /Medical		disease or condition a.	or as a consequence of	-	ropar	hy.	1.				
Examiner	<u>-</u>	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying	MOXITZ  or as a collups of the top	91).	ency	halop	athy				
cuted nd ransit	Examiner	that initiated events	cidney		failu	re					
ate be executed hysician and the burial-transit	cal Ex	resulting in death) Last Due to (	or as a consequence o	of):							
tificate ng phys as the		d	200			-A					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	come pf pregnancy irth 2  Fetal death ant at time of death wn		Ectopic pregnancy Other (specify)			23d.	Date of deliv Month	rery Day	Year
quires that t n signed by uid be detac	by	Part II. Other significant conditions contributing to de	ath but not resulting in	the un	derlying cause give	en in Part I.	23e. Did 1	1/	contribute to		of death? □Unknown
The law recate has bee	Completed						24a. Was auto perfo 1□ Yes	an 2 psy prmed? 2 No	4b. Were aut prior to co death? 1 □ Yes		gs available of cause of
vicani siciani sicertifii	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No Hospital:	npatient 2 ☐ ER/Out	natient	3 DOA Othe		ath <i>(Check only o</i> lome 5 $\square$ Resi		Other (Speci	if <sub>V</sub> )	
nding Phy tth. r: After this e funeral d		27. Manner of Death 28a. Date	of Injury 28b. T	ime of njury	28c. Injun Work		28d. Describe			9)	
To the Hospital or Attend within 24 hours after death. To the Funeral Director: v completely filled in by the f	Certification:		of injury - At home, fan ng, etc. <i>(Specify)</i>	rm, stre	et, factory, office		28f. Location ( City or To	Street and N wn, State)	umber or Rui	al Route N	lumber,
Hospi 24 hour Funer etely fill	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the beand manifere									se(s)
To the To the Comple	Me	29b. Signature and title of certifier	2/2 2/	2 0	29c. License		,		igned (Month		
		myy le	o of double (lies on )	Tues		10351	6	3/4	6/2	000	5
9+1		30. Name and address of person who completed caus  MYUNG HEE NAM, MD /	400 W. 7th	St	. / Frede	erick, Ma	aryland	21701	-		
St Regist		31. Date filed (Month, Day, Year) 1 0 2008	egistrar's Signature	ir .	frest)						

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Records, P.O. Box 68760 Division or Vital To the Hospital To the Funeral Medical within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (VATO) 18 Ter 3001 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APPLO 1114#5, perfit, 3977,3724708, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Tarch 56 Earl Blanding, Jr 7, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Amve If Under 1 Year | If Under 24 Hrs. 8. Pate of Birth (Month, Day, Year) 2-24-1961 5. Social Security Number 213–90–3569 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Yrs. Director MD 221 41 4378 Usual Residence of Decedent 47 with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at N/A 1 XYes 2 No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 USA 310 E. 20th Street Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23: Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Unk Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patricia Evans Earl Blanding , Sr 2 or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. 5302 Cedgate Road Balto, MD 21206 Roberta Branch-Aunt Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-19-2008 Balto, MD Greenmount Cem 21. Signature of Funeral Service Licensee March F/H East 22. Name and Address of Facility lady 21202 1101 E. North Avenue Balto, MD an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence d): Examiner 5/ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pur to (or as a consequence of): tuman tommunudet in rency country to mountable in energy Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? (es 2 No this certificate 1□ Yes the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Mannel of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of continer 29c. License number 17/08 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, 32. istrar's Signature Year) State MAR 24 Registrar 2008

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 2	State of Maryland / 29d per dr., g877	Department 03/24/08d	of Health and M hip Death	ental Hygi	ene g. No. 008	09260
	Physic /Medi		1. Decedent's Name (First, Middle, Las		Wn		2. Date of Death Month March	1	3. Time of Death
	Exami		4a. Facility Name (If not institution, give	eathand Re	hab. 4b. City, To	wm, or Location of Death	1	4c. County of Death	1
	Funeral Director		01 (-30 1120	T. Age (In yrs, last)		Year If Under 24 Hrs. Days Hours Min.	B. Date of Birth Month, Day,	Year) 39 Soul	place (State or Foreign http://camlina
	anyland show ed at	ō	Usual Residence of Decedent  10a. State  10b. County  Mc Wan J	10c. City, To	wn or Location	Ballinge			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itiem 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Medical Examinar must be notified at	by Funeral Director	10e. Street and Number	pad Rd.	10f. Zip Co	21707	10	g. Citizen of What Cour	
	ter death wi	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceder	nt of Hispanic Origin? (Spe Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Americ Black, White,	
9000	"naturat", or it	d by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 D No If Yes, Give Year or Dates:	1 ☐ Yes 2 █			Specify: Bla	cK
21215-0036	vithin 72 the note than "note the note than "note the note that the note	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed)  College (1-4or 5+)	life. DO NOT use	done during most of working retired)	1	6b. Kind of Business/In	dustry
	be filed v ital Hygie id other t event. In	Be	17. Father's Name (First, Middle, Last)		Nurses	18. Mother's Name		laiden Sumame)	7.700
Maryland	should I and Meni s marke	ဥ	Uavid homa  19a. Informant's Name/Relationship (7		9b. Mailing Address (§	treet and Number or Rural		City or Town, State, Zip	Code) 21205
	Health a tem 27 Is		Theresa Washin 20a. Method of Disposition	gton dangter 20b. Place	of Disposition (Name	Kwood Ke	l, Bat	firme Ma Oc. Location - City or To	y State
Baltimore,	Page nent o ant: If ury or	3	1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	LOVY	aire far	KCem, 3/2	4108 1	Noodlawn	Maryland
Bal	permit. Departr Imports any inj	V N	21. Signature of Fundament Service Licens	Parker	22. Name and A	address of Facility and	ve. Ba	Hinore N	ansland
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the death. Do	not enter the mode of	f dying, such as cardiac or	respiratory arres	16ccs	Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequence	e of):	Line 6	all		
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	e of):	and O			
30,	cate be executed physician and the burial-transit	l Examiner	that initiated events resulting in death) Last	c	∋ of):				
68760,	phy:	Aedical		d					
P.O. Box	The law requires that the death certifi te has been signed by the attending l page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregr 5 Other (special			23d. Date of delive Month	ery Day Year
	uires that signed to id be deta		Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying caus	e given in Part I.		acco use contribute to the	
of Vital Records,	law requias been	Completed					24a. Was an autopsy		psy findings available mpletion of cause of
tal R		e Con	25. Was case referred to medical			00 81( 0)	performe	ed death? ZNo 1 ☐ Yes	2□ No
of Vi	Physician: rthis certifica ral director,	To B	1 163 \$ 100	Hospital: 1 Inpatient 2 ER/O				ce 6 □Other (Specify	y)
	fte fte	atlon:	27. Manner of Death  Natural 5 Pending  Accident investigation		Time of Injury M	Injury at Work? 1 Yes 2 No	Bd. Describe how	v injury occurred	
Division	pital or Attano ours after death eral Diractor: filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, street, factory, of	fice 28	Bf. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
4	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledginer: On the basis of examination and manner stated.	ge, death occurred at the nd/or investigation, in	he time, date and place, ar my opinion, death occurred	nd due to the cau d at the time, date	use(s) and manner as si e and place, and due to	ated. the cause(s)
<u>'</u>	To th within To th comp	Me	29b. Signature and title of certifier			cense number		d. Date signed (Month,	
			30. Name and address of person who co	ompleted cause of death (Item 23a)	(Type, Print)	20641		March 19, 2	
			30. Name and address of person who con the filed (Month, Day, Year)  MAR 2 4 2008	201-105/	sack hwe	1 Neck 1	load.	Balhma	2/22/
	Sta Registr	ar ar	MAR 2 4 2008	Jan A Signatur	with				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month March 16, 2008 Year **Physician** 8:00 A.M John Francis Brady /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll 1175 Dingus Drive Westminster If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months **X**M 2□ F 72 215-34-5947 May 16, 1935 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at XXYes 2 □ No Director Maryland Carroll Manchester 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21102 3061 Main Street, P.O. Box 872 America of Funeral 12. Was Decedent Ever in U.S.
Armed Forces? 1958–
100 Yes 2 No
If Yes, Give 1959
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married ŏ 1 ☐ Yes 2XXXVo þ Specify: 3 Widowed 4 Divorced White "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Carpenter Building other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental I ant: If item 27 is marked of ၉ John Edward Brady Rose Agnes Walsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Humbert (Fiancee) Main Street, P.O. Box 872, Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Family Catholic Date 20a Method of Disposition 20c. Location - City or Town, State XBurial 2 Cremation 3 Bernoval from State March 20, 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery Holbrook, Maryland 2008 21. Signature of Fundial Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Part. Inter the disease, or com #cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ship of or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat e ate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1373CE Other: 4 Nursing Home 5 Residence 6 Other (Specify) RESIDENCE 1 Yes 2 No Hospital: dir 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed 68760. Box The law requires that the death O σ. Division or Vital Records, Physician:

02400

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Hospital or Attending 24 hours after death Puneral Director: filled in by within 24

3 ☐ Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifie

30. Name and address of perso

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

tract (xSTmister HI) 21157

29d. Date signed (Month, Day, Year) 20108

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

to completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

March 22 2008

			For State Registrar Certificate of Death		g, No. 2008	09262
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
100	/Medic				22 2003	1:15 PM
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital  Baltimore		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthr	place (State or Foreign
1	Director		578-14-4569   1 M 2 F   91   Yrs.   Months   Days   Hours   Min.	Month, Day, 1	1916 Mar	y land
	puq *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			0d. Inside City Limits
	Maryla f shoved at	ō	Md. N/A Baltimore			1 X Yes 2 □ No
	the 1	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at		100 Harborview Dr. Unit 605 21230		US	Ą
	ems :	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Americ Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【X No If Yes, Give 1 ☐ Yes 2 【XNo Specify: Year or Dates:	,	Consite	
Ş	hour tural' al Ex	d be		10	6b. Kind of Business/In	ite dustry
15	nin 72 n °na Medic	plet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	<i>g</i>	220110000111	,
212	d with giene er tha , the I	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Budget Secretary		State of Ma	aryland
pu	be file tal Hy d oth	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name	,	aiden Surname)	
₹	Men Marke Marke	ဥ	Charles L. Benton, Sr. Minnie			
Ma	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural  19b. Mailing Address (Street and Number or Rural  100 Harborview Dr. Unit			,
ā,	s 1 an f Heal tem 2 other		· · · · · · · · · · · · · · · · · · ·		Oc. Location - City or To	
E O	Pages 1 and 2 ment of Health ant: If Item 27 is ury or other tra		1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Park lawn Mem. Park 3-25-	-08	Rockville,	Md.
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If Is any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility RUCK TOWSON Fur	neral Ho	me. Inc.	
	of Marcell		23a. Part1. Enter the dise e, or complical insit a traused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one complication on each line.	respiratory arres	Md. 21204 st,	Approximate Interval Between
	Physician		Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death)  a. 12 1 (a. F. a. a. Due to (or as a consequence of):			INSER
	Examiner		Sequentially list conditions. b. Chronic lyng chiscuse			5 years
1	be sit	iner	if any, leading to immediate Doe to (or as a consequence of).		. s	
OF.	and and il-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. District Collins  Due to (or as a consequence of):			1 month.
68760,	rificate be executed ng physician and as the bunal-transit					
89	ificate g phy: as the	Medical	a.			
6.4			IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv	•
Э.	the att	Physician/	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.0	30 5	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did toba	acco use contribute to t	he cause of death?
ds,	w requires that been signed to should be deta	by	ORE CONTROL CALIFORNIA CONTROL		s 2 No 3 Pro	
Ö	v requ	etec	Con september of the properties of the september of the s	24a. Was an		
Re	he lay e has	Completed	a shuarduled Barbuated	autopsy perform	ed? death?	opsy findings available impletion of cause of
ta	Physiclan: The la r this certificate has ral director, page 2	Be Co	25. Was case referred to medical 26. Place of Death		1 ☐ Yes	2□ No
>	nysich is cer direct	To B	examiner?		nce 6 Other (Speci	fy)
0	d <b>ing Ph</b> .r After th funeral		27. Manner of Death  1 → Anner of Death  1 → Anner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?	8d. Describe hov	w injury occurred	
sio	tendl leath. tor: A the fu	cati	2 Accident investigation M 1 Yes 2 No			
Division or Vital Records,	I or A: after c Direc	Certification:	4 ☐ Homicide determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Stre City or Town,	eet and Number or Run State)	ai rioute Number,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a			
	he Hc in 24 h he Fu pletel)	Medical	(Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, da	ite and place, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month,	Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

Hassan

Nasser 32. Registrar's Signature

ZOI East

Nasser, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0053617

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROSE BALSER .2008 MAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT & NURSING BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Months Days Hours 216-44-0640 107 MD Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evanal at must be invitibled at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7920 SCOTTS LEVEL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status nours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygis Important: If item 27 is marked other eny injury or other traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **LEGUM** MORRIS GOLDIE COPLAN 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY BALSER / DAUGHTER 130 SLADE AVENUE, #520, BALTIMORE, MD 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARETHGTON<sup>al</sup>CHTZUR<sup>ace)</sup> AMUNO CONG. \* 4 □ Donation 5 □ Other (Specify) 03/21/2008 BALTIMORE, MD 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 11min disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to initious cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence off burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has certificate I 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 0 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 4 Hoursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Till Certhying mystician: To the best of my knowledge, death occurred at the time, date and place, and due to the cades(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 person who completed cause of death (Item 23a) (Type, Print) 243 0 MAR 2 4 32 egistrar's Signature State 402008 Registrar

Division or Vital Records, P.O. Box 68760.

State Registrar

ST. PAUL 32. Registrar's Signature

son who completed cause of death (item 23a) (Type, Print)

31. Date filed (Month, Day,

d address of pe

30. Name a

**ORIGINAL** 

ATTENDER

Ralhmore

19,2008

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State Registrar 31. Date filed (Month, Day, Year) MAR 2 4

30. Name and address of person who

AMICIMH 82. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

900 CATON AVENUE, BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 1:21 PM **Physician** Dolce (Sreadyu 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mary bod Medical University of Center If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 218-46-1541 44 24,1953 Mary/AND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 No Director Harre 10e. Street and Number TARFORD 10g. Citizen of What Country? 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1° Ayes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Year or Dates: Army þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give Kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic...... College (1-4or 5+) Elementary/Secondary (0-12) Herry YOIN+ Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DANIEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ode) 19a. Informant's Name/Relationship (Type. Print) Brother DANIEL DONALD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State BAltimore, Maryling 3-22-08 4 □ Donation 5 □ Other (Specify) Cenetery 21. Signature of Funeral Service Licensee 22. Name and Address of Ficility JOSEPH N. ZANNING Jr. 263 3. Conkline St BARE axre CONKLING ST BARO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Meumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Esophageal Metastatic Sequentially list conditions, Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-transi attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 2 No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Accident 1 Yes 2 No 3 Probably 4 Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Division or Vital Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certificately filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar Philip C. Dittmar 31. Date filed (Month, Day, Year)

29b. Signature and little

of Maryland Medical Center 22 S. Greene St. 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.b

29c. License number

19694

29d. Date signed (Month, Day, Year)

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) O 8 Month **Physician** 5:20 PM Laura Dimick Shirley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Posedali Balhmore Franklin Square Hospital 7. Age (In yrs. last birthday)
72 Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan. 5, 19 If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1 □ M 2 💢 F Jan. Director 212-34-6305 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10b. County 1 X Yes 2 No MD n/a Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number must be n 407 S. Robinson Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Items Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examines 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: Completed by white 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Jenkins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 407 S. Robinson Street, Baltimore, MD Kim Dimick (Daughter) permit. Pages 1 and Department of Healt: Important: If item 27 any injury or other trong. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/26/2008 Timonium, Maryland Dulaney Valley Mem 21. Signatury of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. ISCHEMIC DOWE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): organ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy page performed? Yes 2☑No 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Dr. Ajay Behari

31. Date filed (Month, Day, Year)

9000 Franklin Square Drive

32. Registrar's Signatule

Baltmore

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year RONALD M. DUNTY. SR. 615 A M 3 20 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Center Baltimore Rosedale if Under 1 Year | if Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 □ F 219-58-4976 54 June 9, 1953 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Anne Arundel Glen Burnie 1 □Yes 2¶ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7827 Shellye Rd. 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service 12 Letter Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William George Dunty, Jr. Helen Ruth Brenneman 19a. Informant's Name/Relationship (Type. Print) Patricia A. Dunty (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7827 Shellye Rd., Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Pk 3/24/08 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P 3204 Mountain Rd., Pasadena, Md. Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hypoxemic disease or condition resulting in death) respiratory failure 1 WEEK Due to (or as a consequence of): Stage IV n Due to r as a consequence of): IV nonsmall cell Lung 4 months Sequentially list conditions. ii any, leading to immediate cause. Enter Underlying

**Physician** /Medical Examiner Examine

Physician

/Medical

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Funeral

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Completed

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Examiner

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or ite

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any linjury or other traumatic evone.

Baltimore, Maryland 21215-0036

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by Physician/Medical

Be Completed

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Certification:

Medical

attending physician and for use as the burial-trai

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, signed by the a d be detached f certificate has the irector, page 2 s within 24 hours after death.

To the Funeral Director: /
completely filled in by the f

Cause (Disease or injury that initiated events resulting in death) Last	c. AIFFUSE GIV  Due to (or as a consequence of):	eolar dama	ige	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ictopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	ontributing to death but not resulting in the und	, ,	23e. Did tobacc	o use contribute to the cause of death?
systemic in	r Flammatory re	sponse	1 Yes	2 No 3 Probably 4 Unknown
Syndrome			24a. Was an autopsy performed? 1□ Yes 2□	
25. Was case referred to medical examiner?			th Check onl one	
1 Yes 2 No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred
3☐ Suicide 6☐ Could not be 4☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifler 1 Certifying Phyone) 2 Medical Exam	/sician: To the best of my knowledge, death of iner: On the basis of examination and/or investant manner stated.	occurred at the time, date and place stigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	11	29c. License number	29d. [	Date signed (Month, Day, Year)
Cavolen	Hulm MD	RES0000	3	3-20-2008

State Registrar

9000 FRanklin Square DR

md 21237

Balto

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

DR Candice GlorDano

MAR 2 4

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 3:10 22, 2008 TNNA MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD HARBOR If Under 1 Year If Under 24 Hrs DRIVE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F 214-14-8079 25,1921 Director MACYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Ldgewood Director 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be and injury or other traumatic event, 21040 U.S. A UKKS HARBOR DRIVE Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc., 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 þ Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tomeraker OWN HOME 8+1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood Lohneyer 621 DAKST HARBOE DATENE HAT desty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State CROWNSVILLE, MARY/AND MD reterms Cemetery 3-28-2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
05 cph N. Zannino
63 5 CONKLING 22. Name and Add 263 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Cardiac Immediate Cause (Final AEzent **Physician** disease or condition resulting in death) /Medical Examiner CORONAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner /apa The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of): aftending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2X No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760, Hospital or Attending thin 24 hours at

> State Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 2 4

one)

and manner stated.

T MD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MoHAMMAD TAQIMD 23 SHIPPING PL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0021859

I'Baltimis

29d. Date signed (Month, Day, Year)

24108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM 5 per INF .0878 .47708 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 's Name (First, Mid **Physician** /Medical City, Town, or Location of Death 4c. County of Death Examiner 405, 8. Date of Birth Age (In yrs. last birthday if Under 24 Hrs. 9. Birthplace (State or Foreign A Pountry) A MADAMA **Funeral** Days Hours 1 □ M 2 🚮 Yrs. Director Usual Residence of Dece death with the Maryland 10c, City, Jown or Location 10d. Inside City Limits 10a. 28a-f show 1 Yes 2 No -imole Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2/2/5 ō or items 23a Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, 17 Father's Name (First, Middle, Last 18 Be ant's Name/Relationship 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Licent 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): arlure Examiner ORATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Donknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 death? 1 ☐ Yes certificate 2□ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 pre-tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State MAR 2 2008 4 Registrar

			Please I 1 - State amend #20b Pe	ype or Prin State of Ma er FH G878	arvland	d / Dena	rtment of	Health	and M			ie o (	ible.	0927	)
Tes	Physic /Medi	_	Decedent's Name (First, Middle, Last)     James Girard Ha					- Bouth		2. Date of Month	Death	20. Z	2.008	3. Time of Death	М
)	Examination Examin		4a. Facility Name (If not institution, give s  105. Social Security Number 6. Sex  219-54-0534	eral H	)  Sj) i    e (In yrs. le   5 9	ast birthday) Yrs.	4b. City, Town  Butti If Under 1 Ye  Months Da	MUTE ar if Under	of Death r 24 Hrs. Min.	e. Date of (Month, Dec			of Death n/a  9. Birthpl	ace (State or Foreign)	gn
Н			Usual Residence of Decedent							DCC 2	, '	740	пат у	Tanu	_
	ie Marylan Ba-f show itified at	ctor	MD 10b. County n/a		10c. City	, Town or Loc	ation Balti	more					10	0d. Inside City Limit 1 ☐ Yes 2 ☐ N	
	ath with the 23a or 24 ust be no	Funeral Director	10e. Street and Number 537 Bloom Stree	et			10f. Zip Cod	9 21217			_	S . A	What Coun	try?	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1☆ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent I Armed Forces?  1  Yes 2  I I Yes, Give Year or Dates:			/as Decedent Yes, specify C ☐ Yes 2☐1			ecify Yes or Rican, etc.)	No-	Bla	ce - America ck, White, of SV: Bla	etc.	
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, Maryland	is 1 and 2 should Health and Mitem 27 is mariother tranmati	F	19a. Informant's Name/Relationship (Type Hazel Rogers /	*		l_	Address (Str							Code)	
Baltimore,	Pages 1 ment of He ant: If item ury or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Ro 4 → Donation 5 → Other (Specify)	emoval from State	20b Pl	ace of Dispos The <b>Carne</b> Nity	ition (Name of Cenc Cemet	tery ery		9.08			-City or To		
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service License	arris	·	Ch 52	Name and Ad atman 40 Re:	dress of Facil Harr isters	is F stow	unera n Rd.	ıl H Ba	ome ltin	nore,	MD 2121	5
	Physician		23a. Pert1. Enter the dis-y-se, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused e cause on each lin	the death ne.	. Do not ente	r the mode of	dying, such a	s cardiac	or respirator	y arrest,			Approximate interval Between Onset and Death	
18	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as  MCYALL)  Due to (or es	Ilm 1	Resista	nt Sto	sphijlo.	loll	us Au	gens	Bac	terium		
8760,	cate be executed ohysician and the burial-transit	70	resulting in death) Last	Due to (or as	e consequ	ence of):									
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 □	Ectopic pregna Other (s <i>pecif</i> y			-147			ate of delive onth	ry Day Year	
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o o	Physic this c	P.	1 ☐ Yes 2 No	ospital: 1 12 Inpatie		R/Outpatient 28b. Time of	3 DOA			me 5 R				/)	_
Division or	Attending Physician: r death. ector: After this certifica by the funeral director, I	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day	(Year)	Injury	M 1	njuryat Vork? □Yes 2□	]No	28d. Describ				l Route Number,	
<u>&gt;</u>	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide determined  29a. Certifier 1 ☑ Certifying Phys	building, etc	c." (Specify,	)				City or	Town, Sta	ate)			
	ne Hos	Medical	(Check only 2 Medical Examin	er: On the basis of and manner sta	examinati	on and/or inv	estigation, in n	ny opinion, de	eath occur	red at the tir	ne, date a	and place	, and due to	the cause(s)	
	To the within 2 To the comple	Me	29b. Signature end title of certifier	M-P			29c. Lio	ense number	ryl		29d. [	Date sign	ed (Month, 1	Day, Year)	

State Registrar

DHMH 17 Rev 1/2001

Couls

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARDA HAMELO

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Hak Now Hame-Ea 31. Date filed (Month, Day, Year) MAR 2 4 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ State		ment of Health and M icate of Death		2000	09272
		Registrar  1. Decedent's Name (First, Middle, Last)	Coran	cate of Death	2. Date of Death	j. No,	3. Time of Death
Physic /Med		Wayne Louis Harting			Month	Day 2008	6759A M
Exami		4a. Facility Name (If not institution, give street and number)	46	City, Town, or Location of Death		4c. County of Deat	
		DI Ugnes Hospital		Baltimore		N/A	
Funera Director		5. Social Security Number 6. Sex 7. Ag 1 M 2 □ F 7. Ag		Under 1 Year If Under 24 Hrs. Onths Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign untry)
系		Usual Residence of Decedent	71		00-20-19	730 Md	ryland
ryland		10a. State 10b. County	10c. City, Town or Location	on			10d. Inside City Limits
ne Ma	Director	MD Howard	Elkr	idge			1 🗋 Yes 2 🔀 No
with the	Dire	10e. Street and Number	1	0f. Zip Code	10g	J. Citizen of What Co	untry?
eath ve 23	Funeral	5945-D Abrianna Way  11. Marital Status 12. Was Decedent	Ever in II S 13 Was	21075	Porty Voc or No.	United St	
fter dea	Ē	Armed Forces?	If Yes	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
036 ours a	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1958	Yes 20 No Specify:		Specify:	White
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. http://www.inatural.or.tteme.23a.or.28a-f.show ent, the Modical Exempter must be notified.	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind	s Usual Occupation of work done during most of worki	ng 16	b. Kind of Business/	
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d 212 filed withi Hygiene. other than		17. Father's Name (First, Middle, Last)		chine Operator  18. Mother's Name	(First, Middle, Ma	Bakery	
E galaba	To Be	Louis O. Harting		Mildre	ed Rollma	'n	
Maryland 2 d 2 should be filed the and Mental Hygi 77 in marked other traumatic svent, 1		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ad	ddress (Street and Number or Rura			Zip Code)
E 8 = 8 E		Patricia A. Harting - wife	and the second s	Abrianna Way, I		Maryland	21075
Baltimore, semil. Pages 1 ar Semil. Pages 1 ar Separtment of Heal mortant: If item in piolary or othe more.		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disposition cemetery, cremator	ar ar ather alesa)	oate 20 rch	c. Location - City or	Town, State
Itim It. Pa rtmen rtent:		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee MOOC	Meadowridge	A STATE OF THE PARTY OF THE PAR		lkridge,	
Baltimore permit. Pages 1 Department of H Important: If its any injury or ott		21. Signature of Funeral Service Licensee MOOC		me and Address of Facility Gai , Inc., 7250 Was			ral Home at
Appr		23a. Part1. Enter the disease, or complications that caused	the death. Do not enter the				Approximate
Physician		shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	10.	dial infarcti			Interval Between Onset and Death
/Medical		resulting in death)	a consequence of):	or or infarer	CH		unknown
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58760, Expression and physician and sthe burial-transit	edicai E	d.					
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Box 6 Box 6 eath certifi	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		pic pregnancy		23d. Date of deli	*
Records, P.O. Box (The law requires that the attending bage 2 should be detached for use a	Physician/M	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Yes 2 □ No 9 □ Unknown		er (specify)		Month	Day Year
P. P. that the detac	Ph	Part II. Other significant conditions contributing to death by	ut not resulting in the under	ving cause given in Part I	23e. Did tobac	cco use contribute to	the cause of death?
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The lay age 2	Completed				autopsy performe 1 Yes 2	prior to death?	2 No
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of V		1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatie			me 5 Residenc	ce 6 □Other (Spe	afy)
vision of Vita	in o	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injur (Month, Da)		Work?	28d. Describe how	injury occurred	
Division 1 or Attending after death. Director: Afte	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	ury - At home, farm, street, f		28f Location (Street	et and Number or Ru	ural Route Number
Div	Certification: To	4 Homicide determined building, eld	c. (Specify)	actory, office	City or Town, S		TODIO TOTTOGI,
Division of Vital Ra Division of Vital Ra To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate h completely filled in by the funeral director, page	cai C	29a. Certifier 1 Certifying Physician: To the best of Check only 2 Medical Examiner: On the basis of	of my knowledge, death occ	urred at the time, date and place,	and due to the caus	se(s) and manner as	stated.
the H in 24 the Fi	Medical	one) and manner sta	examination and/or investigited.				
To	2	29b. Signature and title of certifier		29c. License number 7 473 53		Date signed (Monti	
141		M			100	wich 21,	Lev I
154		30. Name and address of person who completed cause of de Jun (2007)	00 Caton Avenue	Baltimore M	wyland	21229	
St	ate	31. Date filed (Month, Day, Year) 32 Registra	tr's Signature	4,	/ 1		
Regist	rar	MAR 2 4 2008	U SU JUJUNG				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 8878 4-2-08 yt Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LAURA 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ritchie Joseph
5. Social Security Number If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 075-28-5407 M 27 Hours Director 7-7-1935 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md. BALTO. 1 Yes 2 □ No Director 10g. Citizen of What Country? 1400 E. MAdison ST. Apt 309 21205 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: B/ACK 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY WORKER LAU

18. Mother's Name (First, Middle, Maiden Surname

Helen Bullock LAUNDRI or other traumatic event, 17. Father's Name (First, Middle, Last) f Health and Mental Item 27 is marked o ARTHUR HOWARD Informant's Name/Relationship (Type. Print)

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

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Due to (or as a consequence of): **Physician** LY EAT /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certi icate Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PICE 1 Tes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier e of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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CHARLES ST, BOLTHORE, MI) 21040.

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μρ 65 Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 07:20AM 18, 2008 MARCH /Medical Odessa Josephine Hutchins 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTERTOWN NURSING & REHAB CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Director 220-38-9844 8/31/1938 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 MORGNEC RD. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. by Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) N/A Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Seney ည Mary Lee Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Culley -Daughter 2417 Ashland Avenue Balto, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3-25-2008 Balto, MD Greenmount Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility March F/H East Snaph Mule 1101 E. North Avenue Balto, 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac prespiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician VONIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy Q V 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 🔲 Inpatient 4☐ Nursing Home 2 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manne Death filled in by the funeral 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 Accident 2 🗌 No Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on and manner stated 29b. Signature and title of

State

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31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year

2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma		partment of F ertificate of			/ 111	08 09275
	* *		Registrar     Decedent's Name (First, Middle, La.	st)		ertinicate or	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
يفعتني	Physici /Medic			orinthea	LaShawi	n Hooks		Month MARU	1 10 .	Year 5:55 PM
7	Examin		4a. Facility Name (If not institution, giv	e street and number)			r Location of Death	1111100	4c. County of	1008
3				NOOD CEN			IMORE			
	Funeral Director	i	5. Social Security Number 6. S	ex 7. Age □M 2X1F	(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
			213-86-6931 Usual Residence of Decedent		36			7-29-	1971	MD
	arylan show d at	_	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	the Mi 28a-f	Director	MD  10e. Street and Number	N/A	Baltir				10. 0" (11	1 XYes 2 No
	Mith Ba or		4820 Aberdeen	λιιοριιο		10f. Zip Code	=		10g. Citizen of W	nat Country?
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 1	21206 3. Was Decedent of H If Yes, specify Cuba		cify Yes or No-	U S A	- American Indian,
36	i within 72 hours after death with the Maryland jiene. t'than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fu	1X Never Married 2 ☐ Married	1 ☐ Yes ANO	,	1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Specify:	k, White, etc. Black
5-0036	tural'	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a De	cedent's Usual Occup	ation		16b. Kind of Bus	
215	hin 72 e. In "na Medic	plet	(Specify only highest gra	de completed)  College (1-4or 5+)	- (Gi	ve kind of work done of the DO NOT use retired	during most of working)	ng	TOD. KING OF EGS	N/A
21	filed within Hygiene. Ither than "	Completed	9th_grade		' <b>,</b>   .	sabled				
Maryland	d d d	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			<del>)</del> )
<u> </u>	should ind Men marke	우	William C. Hoo  19a. Informant's Name/Relationship		19h Ms	illing Address (Street	Evelyn			State 7in Codel
	d 2 th a 7 is		William C. Hoo	,		)6 Eastbu				MD 21202
Ze,	of H		20a. Method of Disposition			position (Name of rematory or other place	-	ate		City or Town, State
Ĕ	Pages ment of lant: If ite		1 Denation 3 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification)		1	Memorial	Pk 3-25-	-2008	Randall	lstown, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer			22. Name and Addres			'/H Eas	
			23a. Part1. Enter the disease, or com	olications that caused the	he death. Do not e					MD 21202 Approximate
	hysicían		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final			Y PITOM A		, respiratory ai	1001,	Interval Between Onset and Death
,	/Medical		disease or condition resulting in death)	a Oue to (or as a	consequence of):	471/010				
	Examiner		Sequentially list conditions.	b. A /	DS					
T	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	1				
J	execut and al-tran	Examiner	that initiated events resulting in death) Last	c	consequence of):	ECTION				
8/PU	ficate be executed physician and is the burial-transit	dical		.d						
	ertifica ing ph e as th	Medi	IF FEMALE:		NINO.					
Š P	the death certifi y the attending p iched for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 mopths?	23c. If yes, outcome pf	Fetal death	B □ Ectopic pregnancy			23d. Date Mon	of delivery hth Day Year
o.	the de	ysic	1 □ Yes 2 ⊡ No 9 □ Unknown	4□Pregnant at ti 9□Unknown	me of death 5	i ☐ Other (specify)				an Day Tour
7	w requires that the de been signed by the should be detached	Y Ph	Part II. Other significant conditions o	ontributing to death but	not resulting in the	un rlying cause give	en in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
ecoras,	equire:					~		1 🗆 Y	es 2 10 10 3	3 ☐ Probably 4 ☐ Unknown
13	law reas bea	Completed						24a. Was a		Vere autopsy findings available rior to completion of cause of
=	: The	Com						perfor	rmed? 💄 de	eath?
VII	stcian certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		ant 30 DOA Othe	26. Place of Death			
5	Physer this eral di	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	28b. Time	ent 3 L DOA	4 I Nursing Hon		lence 6 Other	
0	nding ath. r: Afte e fune	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )	Year) Injury		Yes 2 □ No		on injury occurre	u .
DIVISION	ir Atte er dea irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc.	/ - At home, farm, s (Specify)	street, factory, office	2	8f. Location (S City or Tow		r or Rural Route Number,
2	pital o urs aff eral D illed ir		00-0-455						,	
	e Hos 24 ho e Fune etely f	Medical	(Uneck only 2)   Medical Exam	ysician: To the best of niner: On the basis of e and manner state	vamination and/or	investigation in my o	ninion doath occurre	ad at the time	data and place atch	nd due to the course(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Me	29b. Signature and title of centrici	ATTENDIN	& PHYOR	29c. License	number	2	29d. Date signed	(Month, Day, Year)
				1)		200	62239	7	MARCH	19 2008.
	9 10 10 10 10 10 10 10 10 10 10 10 10 10		29b. Signature and title of certification.  30. Name and address of person who certification.  6701 Nor 76.  31. Date filed (Month, Day, Year)	completed cause of dea	th (Item 23a) (Type	e, Print) MAW	MAING	00)	MD	2 2 4 2
	Stat	e.	31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	· SUITE	4200	Tows	on, M	0 41204
	Registra	ar	MAR 2 4 20	08 Desir	S A	parter				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Myrtle Maxine Hogan /Medical March 21. 2008 11:15 A M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Cherrywood Reisterstown Baltimore 8. Date of Birth (Month, Day, Year) Oct. 7, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 M XX F Director 408-66-0648 65 1942 Tennessee Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes XX No Owings Mills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11 Wingate Court Completed by Funeral 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 □ Yes X No 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burl Reynolds ဥ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Heatth an Important: If Item 27 is i any injury or other traur once. Harold A. Hogan / Son 11 Wingate Court, Owings Mills, MD 21117 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 3/22/08 Baltimore, MD 21. Signature of Fundal-Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117 mac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Yes 2 W 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to neath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 2 No 3 Probably 4 Unknown

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. physician as nse for page After iours after death, neral Director: / filled in by the f e Funeral I

Baltimore, Maryland 21215-0036

	Esmentin	24a. Was an autopsy performed	24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 [	th (Check only one)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	
3 Suicide 6 Could not b	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street, facto	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

30. Name and a of person

State Registrar

Medical

31. Date filed (Month, Day,

2008

To the Hospital

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** HARTLEY IDA E. 200897 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 61-en ISMYDI Baltimore Washington Med. Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 ☐ M 2 😿 F 81 220-12-7832 Director 1,1926 April Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be men more ment of Health and Mental Hygiene.
ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show
jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐Yes 2 No Director Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7355 Furnace Branch Road 21060 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary Elementary/Secondary (0-12) College (1-4or 5+) Curtis Engineering O 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cwalina Stanislaus Pajak Victoria 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald G. Hartley (Son) 10375 Golden Ridge Drive, Wadsworth, Ohio 44281 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or Glen Haven Mem. Park 03-22-08 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 11/2 Aart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons agreence of): **Examiner** Sequentially list conditions, if any conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Physician/Medical law requires that the death certificate as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 4 □ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed? es 2 No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes npatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical (Check only one)

Records, Vital Hospital or Attending Physician: o Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu hours after death.

Maryland 21215-0036

Baltimore,

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 24 2008

nd title of ce

29b. Signature



and manner stated.

30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2223 othy Imes		Please Type or Print in Black Indelible State of Maryland / Department 1-For State amend #5 Per FH G877 3/26/18/8/at-	of Health and Mental Hygiene							
Physici	an/	1- For State amend #5 Per FH G877 3 Certificate Registrar 1. Decedent's Name (First, Middle,Last)	## Reg. No.    2. Date of Death							
Exam	iner	TIMOTHY IMES  4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital	4b. City, Town, or Location of Death  Baltimore  Ac. County of Death  N/A							
Funeral Director		214-86-3276   LAW - 45	Yrs. Months Days Hours Min. 06/13/1962 Foreign MARYLAND Country)							
and show any nce.	  -	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Low           MARYLAND         N/A         BALTI	IMORE 1 X Yes 2 No							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In properant: If item 2 7 is marked other than "natural", or items 23a or 28a-f show iming or other reasmatic event, the Medical Examinier must be notified at once.	al Director	10e. Street and Number  3221 ELMORA AVENUE  11. Marital Status  12. Was Decedent Ever in U.S.  13. Marital Status	U.S.A.  Was Decedent of Hispanic Origin? (Specify Yes or No-  14. Race - American Indian, Black,							
after death w al", or items iner must be	by Funeral	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 XX No 1 Yes 2 XX No 1 Yes 2 XX No 1 Yes 2 XX No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.  Yes 2 X No specify: Specify: Specify: BLACK edent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry							
336 thin 72 hours ne. - than "natur ledical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  12th grade  SEC	ng most of working life. DO NOT use retired)  CURITY GUARD SECURITY							
21215-0( Ild be filed wi Mental Hygiel narked other	o Be Cor	VIDCII IMEC ID	18.Mother's Name (First, Middle, Maiden Surname)  ALMETA IMES  [ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
re, MD 2 11 and 2 shou F Health and M fitem 27 is n		Marlene Imes-Mitchell/Sister 32	233 Lyndale Ave., Baltimore, Maryland 21213 isposition (Name of cemetery, or other place)  Date 20c. Location - City or Town, State							
Baltimo permit. Pages Department or Important: 1		Signature of Funeral Service Diceosee   VILL LAM C BROWN COMMUNITY FUNERAL HOME P.A.								
ysiciai // dida Examine		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Cardiovascular D	nter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval  Between Onset and  Death							
	١.	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of):  Due to (or as a consequence of):								
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ici pe	ched for use as the burial - us	UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy Month Day Year							
O. Box 687 is the death certificed by the attending p			Other (Specify)  In the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown							
es the	, page 2 should be de		24a. Was an autopsy findings available prior to completion of cause of death?							
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ivision of V or Attending Phy after death. Director: After th	ਰ ⊩		me of Injury 28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City							
O we will be seen that the first of the seed of the se										
To the Hospital within 24 hours	completely	(Check only one)  2 Medical Examiner: On the basis of examination and/or invalid and manner stated.  29b. Signature and title of certifier	vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  March 20, 2008							
C	,	30. Name and address of person who completed cause of death (Item 23a)  Pamera E. Southall, MD Assistant Medical Examiner								
Reg	Sta	te 31. Date filed (Montage Y2/)4 2008 32. Registrar's Signature	Sparle OCME							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Thelma Johnson 15, 1:35A M 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 248-38-8734 1 □ M 2 💢 89 Yrs. 1918 S.Carolina Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County nd Mental Hygiene. nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at MD N/A Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2715 E. Biddle St. 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) 6th Grade College (1-4or 5+) Public Sch. System Cafeteria Worker Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Odell McCoy Estelle Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3724 Bonview Ave. Baltimore, Maryland 21213 Deborah Evans/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5√Other (Specify)Entombment 3/19/08 Pikesville, MD Druid Ridge Cem! 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home aller Harris 4210 Belair Rd. Baltimore, Maryland21206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ine scar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA pice Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. G B 6701 nc 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 4a. Facility Name (If not institution, give street and number) Jordan March /Medical 19 2008 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore C If Under 1 Year If Under 24 Hrs. rs. 8. Date of Birth Hopkins Hospital Johns 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**□M 2□F Days (Month, Day, Year) 7-17-1941 Hours 212-36-1523 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD N/A Baltimore 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 1705 E. Eager Street Apt 111 21202 S Α 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Black 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Broadway Service Supervisor of Housekeep 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ George W. Jordan, Sr Georgett Booth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 E. Eager Street Apt 111, Georgett Jordan-Mother MD 21202 permit. Pages 1 a
Department of Hec
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3-25-08 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1 Sul n Mark 1101 E. North Avenue Balto, 21202 MD23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Acute Renal month /Medical Due to (or as a consequence of): Examiner Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0011 Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): physician at the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day 5 Pending investigation spital or Attendii lours after death. neral Director: A r filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Beer. MEDICAL POCTOR R65-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 Bueso, The Johns Hapkins
Month, Day, Year)

32 Registrar's Signature Hospital, 600 N. Wolfe St. Baltimone, Maryland 31. Date filed (Month, Day, Year) State MAR 2 4 2008 Registrar **ORIGINAL** 

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			1- For State  Registrar  Certificate of Death	Reg. No.	100 0720		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  2. Date	of Death	3. Time of Death		
<i>y</i> ı -	"ral Exami	ner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	ch 18, 2008	2233 hrs		
			3407 Woodstock Street  Baltimore	NIA			
	Funeral			te of Birth (MM/DD/YYYY)	9. Birthplace (State or		
	Director		2/3-96-0308 15M 2 F 27 Yrs. Months Days Hours Min. A4	19-22, 1980	Foreign Country) Margland		
	<b>»</b> :	Ī	Usual Residence of Decedent		10d. Inside City Limits		
	Ow any	Funeral Director	10a. State 10b. County 10c. City, Town or Location  Maryland PIA 938 Ashland Avenue		1 Yes 2 No		
	J036 within 72 hours after death with the Maryland tene. ere than "natural", or items 23a or 28a-f show Medical Examiner must be notified at once.		10e. Street and Number 10f. Zip Code	10g. Citizen of Wha	at Country?		
			938 Ashland Court 21202	United St	lates		
	h with ems 23 be no	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes) 1 Never Married 2 Married Armed Forces? 1 Player Married 2 Married Armed Forces?	es or No- etc.) 14. Race - White,	American Indian, Black, etc.		
0	er deat , or ite				Black		
1	urs afte	ğ	or Dates:				
1	72 hou n "nai	etec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	11	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
\	yo36 within iene. er tha	Completed	Clerk	Hosp	01+21		
	21215-0036 uld be filed within 7 Mental Hygiene. marked other thar c event, the Medica	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, I	Middle, Maiden Sumame)	Come		
	2121 buld be f I Mental marked ic event,	10	10 Informatic Name (Delationatic (Type Drint)	wite Alumber City of Tour	State 7in Code)		
	MD nd 2 sho afth and m 27 is saumati		Kosa Diane Williams - Mother 938 Ashland Court	t Baltoma	N MO 21202		
	S 1 al		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Place of Disposition (Name of cemetery, Crematory or other place)	20c. Location -	City or Town, State		
			1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  King Men Park Dack L	5,768 Kuku 11	sten, NO		
	Balt permit Depart Impor injury		21. In ure of Funeral Service Licensee  22. Name and Address of Facility  21. Address of Facility  22. Name and Address of Facility  22. Name and Address of Facility  23. The Line of Funeral Service Licensee	Pass Bulle,	10 212 29		
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira	atory arrest, shock, or hea	rt Approximate Interval Between Onset and		
	Medical _xaminer	al failure. List only one cause on each line.  Immediate Cause (Final disease a. Acute Coronary Artery Thrombosis Death					
			or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  b. Focal Atherosclerotic Cardiovascular Disease				
		ner					
		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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	760, cate be exe physician he burial -		MENDED 23a-b, 27 per ME g877 3/25/08 amh				
	876 tificate ng phy as the			23d. Date of Month	delivery Day Year		
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	the de ched f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contri	bute to the cause of death?		
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	rds, requir been s		2		Vere autopsy findings available prior to completion of cause of		
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	Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the finneral director, page 2 should be			Describe now injury occurr	eu		
	ivisior  or Attend after death Director:	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Lo		er or Rural Route Number, City		
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	Division of Vital Records, P.O. Box 68760, To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi						
	To the Howithin 24 h	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tile and manner stated.  29b. Signature and title of certifier  29c. License number		ed (Month, Day, Year)		
		-	Cale & C Hall Cale Oc.C.M.E.	March 19,			
			30. Name and address of person who completed cause of death (Item 23a)				
			Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
	Si Regis	tate	W. M. Marian M. M. Marian M. M. Marian M. M. Marian M. M. Marian M. M. Marian M. M. M. Marian M. M. M. M. M. M. M. M. M. M. M. M. M.				
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ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **FRANCES** KLEINMAN 2',40P M 2008 <u>රි</u> March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A ROLAND PARK PLACE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 06/03/1911 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months Days 1 □ M 2 🗙 F NY 131-34-7807 96 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A BALTIMORE 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 840 W. 40TH STREET 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) **TEACHER EDUCATION**

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or important: if Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be n one. Baltimore, Maryland 21215-0036 Physician

For State Registrar

10a. State

MD

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ural", or Items 23a or 28a-f shov I Examiner must be notified at

Director

Funeral

the Maryland

/Medical Examiner

after death.

I Director: After this d in by the funeral di within 24 hours aft

To the Funeral Di

completely filled in

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

To the

by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 L Yes 2 L	No S	pecify:			Specify:	MUTIC	
eted	15. Decedent's Edu (Specify only highest grad	16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  TEACHER			ng	16b. Kind of Business/Industry  EDUCATION				
Be Completed by	Elementary/Secondary (0-12)					3					
e C	17. Father's Name (First, Middle, Last)				18.	Mother's Name	(First, Middle,	Maiden	Surname)		
To B	LOUIS		KOPI	)		YET	TA		S.	TOLLER	
-	19a. Informant's Name/Relationship (Ty	rpe. Print)	19b.	Mailing Address (S	treet and	Number or Rura	l Route Numb	er, City o	r Town, Sta	ite, Zip Code)	
	SHEILA SACHS / DA	UGHTER	5	ROLAND M					210		
	20a. Method of Disposition  1	Removal from State	emeter	Disposition (Name y, crematory or othe DAVID	of er place)	03/21	/2008			y or Town, Star NEW YO	
	21. Signature of Funeral Service Licens	Z.		22. Name and R		Facility SO RSTOWN				OS., IN LE, MD	
8 7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										
	disease or condition resulting in death)	a. Due to (or as a conseq		1-22 WOVI (V							4-
7	Sequentially list conditions,	sti:						tyen	\Y		
amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	U	اد ک ح	es dementia						844	iacs
cal Ex	resulting in death) Last	Due to ( <del>of</del> as a conseq	uence (	of):							
ledi											
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	I death	death 3 Ectopic pregnancy			23d. Date of delivery Month Day Year				
/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contrib								ise contribu	ite to the caus	e of death?
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3e C	25. Was case referred to medical examiner?	25. Was case referred to medical 26. Place of Death (Check only one)									
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ation:	27. Manner of Death  1 Manual 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		ime of 28c njury M	Injury at Work? 1 ☐ Yes	2 No	28d. Describe	how inju	y occurred		
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	f injury - At home, farm, street, factory, office 28f. Location City or To		28f. Location ( City or To	(Street and Number or Rural Route Number, Town, State)					
Medical Certification: To Be	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Me	29b. Signature and title of certifier			29c. License number				29d. Da	te signed (#	Month, Day, Ye	ear)
	N I	Lenthal MD			D31025 March 18, 20			8,200	8		
	30. Name and address of person who co	ompleted cause of death (Item			VNO	d 200				/	

DHMH 17 Rev 1/2001

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Registrar

State

31. Date filed (Month, Day, Year)

MAR 2 4 2008

32. Pegistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** 18, MARCH 2008 7:50P M RUTH N T.E.E. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Yea May 26, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** China 1 □ M 2 🔀 F Months Days Hours Min. 578-52-2569 Director 104 1903 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1122 Jade Drive 21014-2429 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or iten other traumatic event, the Medical Examines 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Chinese Specify 3 X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Niu Unknown Unknown Unknown permit. Pages 1 and 2 should Department of Health and Men ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Lee (son) 1122 Jade Drive, Bel Air, MD 21014-2429 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem Grdns 03/26/2008 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Furting Service Licenses Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hovanced Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be execu Due to (or as a consequence of): attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day ed by the a detached for 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>}</u> 1 ☐ Yes 2 You 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1∐ Yes 2 No Physiclan: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 ☐ Pending To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

10

Baltimore, Maryland 21215-0036

Box 687600

P.O. |

Division or Vital Records,

Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Protine

31. Date filed (Month, Day, Year) MAR 2 4 2008

Tonday.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

PANDEY, 400 West 7th Street, Frederick, Maryland

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

3-20-2008

08-02027	
April Montford	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oril Montford	State of Maryland / Department of Per FH G877 Ceres	artment of Health and Mental Hi rtificate of Death	ygiene Reg. No.				
Physician/ edical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year March 14, 2008  3. Time of Death 1550 hrs				
euicai Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
Comment	University Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. I	Baltimore  Ist birthday) If Under 1 Year If Under 24Hrs	N/A  . 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or				
Funeral Director	148-64-3599 1 M 2XF 40	Months Days Hours Min	- 1e				
uy	Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Location	10d. Inside City Limits				
Maryland 28a-f show any d at once. ector	MD N/A	Baltimore	1XXYes 2 No				
<u> </u>	10e. Street and Number 410 W. Franklin St. Apt.	10C 10f. Zip Code 21221	10g. Citizen of What Country? USA				
or items 23a r must be n.4.	11. Marital Status  1 XXNever Married 2 Married Armed Forces?						
s after de rral", or niner m	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2X No specify:	Specify: Black				
2 3 1 7	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of volume during most of working life. DO NOT use reti					
5-0036 ed within 72 hour hygiene. other than "nature Medical Exant Completed	8th Grade	N/A	N/A				
21215-0036  9 Uid be filed within 72 hours after all Mental Hygiene, in marked other than "natural", ic event, the Medical Examiner.  To Be Completed by	17. Father's Name (First, Middle, Last) Fred Montford		e (First, Middle, Maiden Sumame) ine Johnson				
	19a. Informant's Name/Relationship (Type, Print) Madeline Lawrence/ Mother	19b. Mailing Address (Street and Number or 5818 Marluth Aven	Rural Route Number, City or Town, State, Zip Code) ue Baltimore, MD 21206				
ore tra	1 Burial 2 XXCremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State				
<b>E</b> 4 5 5 5 1	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee		/18/08 Baltimore, MD				
Balti permit. Departm Imports injury o	Culler Haves	4210 Belair Rd.	atman-Harris Funeral Hom Baltimore, Maryland2120				
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.		or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death				
⊤xaminer	Immediate Cause (Final disease or condition resulting in death)  a. CILICATIONS OF Due to (or as a consequence of the condition)	Gunshot Wound to Torso					
1	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	of):					
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of	of):					
cecuted n and transit	d.						
0, be est siciar burial			23d. Date of delivery				
687 ertifica ding p e as th	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of d	2 Fetal death 3 Ectopic pregn					
the death or by the attentched for us	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)					
D. that det		resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 ✓ Unknown				
			24a. Was an autopsy findings available prior to completion of cause of				
2 2 2 2 E			performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No				
Vital Recystions: The chistocher, page director, page on Be Con	examiner?	26.Place of Death (Check ER/Outpatient 3 DOA Other'4 Nursi	only one) ng Home 5 Residence 6 Other:				
n of Vi ding Physi After this funeral di	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred				
Division tal or Attendi rs after death. al Director: /	Natural 5 Pending 1985 Investigation 1985	Unknown  1 Yes 2 X No nome, farm, street, factory, office building, etc.	Subject was shot 28f. Location (Street and Number or Rural Route Number, City				
Division o spital or Attending hours after death. neral Director: Afte filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) Unknown	ionie, jami, strock, factory, omee ballenig, etc.	or Town, State) Unknown				
Division  To the Hospital or Attent within 24 hours after death within 24 hours after death. To the Funeral Director: Completely filled in by the Completely filled and the the dedical Certification.	29a. Certifier 1 Certifying Physician: To the best of my knowled one) Wedical Examiner: On the basis of examination	dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)				
T No To	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
	30. Name and address of person who completed cause of death (Iter	O.C.M.E.	March 15, 2008				
	Ana Rubio MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2120	1				
State Registra	220m - 20000 Pr	ture doest					

DHMH 17 Rev 1/2001 OCME 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOR	epartment of Health and M	ental Hygien			
	_		Registrar	Certificate of Death	Reg. N			
	Physicia	an	1. Decedent's Name (First, Middle, Last)			ay Year 2.5 M		
	/Medic	al	WILLIAM E. MEYE	4b. City, Town, or Location of Death		C. County of Death		
<b>3</b>	Examin	er	4a. Facility Name (If not institution, give street and number)  Howard County General Hospital	Columbia				
F	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Howard  9. Birthplace (State or Foreign		
	Director		212-28-3818 1™ 2□F 76 Y	rs. Months Days Hours Min.	(Month, Day, Yea 12-31-193			
	P.		Usual Residence of Decedent					
	arylar show d at	ř	10a. State 10b. County 10c. City, Town of			10d. Inside City Limits 1 ☐ Yes 2☐ No		
	he M 28a-f otifie	ecto	MD Baltimore  10e. Street and Number	Catonsville	10~ 0	Citizen of What Country?		
	a or 2	Ρ̈́	312 Radstock Road	·	10g. C			
	ns 23 musi	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	21228  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	United States  14. Race - American Indian,		
0	of iten		Armed Forces?  1 ⊠Never Married 2 ☐ Married  If Yes, Give		Rićan, etc.)	Black, White, etc.		
12-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 Widowed 4 Divorced Year or Dates: 1950	1 ☐ Yes 2 ☑ No Specify:		Specify: White		
ה ה	72 h 'natu dical	Completed	(Specify only highest grade completed) (	Decedent's Usual Occupation Give kind of work done during most of worki		Kind of Business/Industry		
7	within 72 ene. than "nai he Medic	ם	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Omputer Analyst	77			
N	e filed v al Hygie other i vent, th		17. Father's Name (First, Middle, Last)	<u> </u>	INd C (First, Middle, Maide	icnal Security Agen.		
and		To Be	William E. Meyer, Sr.	Johann	a D. Coone			
<u></u>	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic ev	ř		Mailing Address (Street and Number or Rura		J		
<u>S</u>	and 2 salth a n 27 is er tra		James Meyer - brother 862	21 South Bali Court,	Ellicott	City. MD 21043		
ē,	ss 1 a of Hei		20a. Method of Disposition 20b. Place of I	Disposition (Name of		Location - City or Town, State		
È	Pages nent of ant: If its ary or o		Mail 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Meadown			kridge, Maryland		
Salt	permit. Pag Department Important: I any injury o		21. Signature   Funeral Service Lice See MO0053	22. Name and Address of Facility Ga.	ry L. Kauf	man Funeral Home at		
_	g D E # 9			MMP., Inc. 7250 Wash				
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		-10~			
	Examiner		Due to (or as a consequence of	ARTEMY DISE	AIS			
	Fig. Co.	ē	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		7)] _			
3.	outed id ansit	Examine	that initiated events — c					
Š	e exerian ar		resulting in death) Last Due to (or as a consequence of	):				
8/60	death certificate be executed e attending physician and d for use as the burial-transit	dical	d					
٥ ×	ertific ding p	Φ	IF FEMALE: 23c. If yes, outcome pf pregnancy					
gox	leath certific attending p I for use as	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	110	23d. Date of delivery Month Day Year		
j.	the y th	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown					
7. J	requires that een signed b nould be deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobacco	d tobacco use contribute to the cause of death?		
ğ	equire an sig	Completed b			1 ☐ Yes	2 No 3 Probably 4 Unknown		
ecords,	law re as ber 2 sho				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
r	The ate h	Som			performed? 1□ Yes 2	death?		
VITal	sician: The law certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)			
0	this ald	မ	1			6 ☐Other (Specify)		
	dling I	ion:	Natural 5 Pending (Month, Day Year) Inj	me of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred		
UIVISION	Attending or death. ector: After by the fune	licat	3 Suicide 6 Could not be 28e. Place of injury - At home, farr		28f, Location (Street	and Number or Rural Route Number,		
<u> </u>	al or Attendli s after death. Il Director: A d in by the fu	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ate)		
	To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.		29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and					
	the Ho in 24 the Fu	ledical	one) and manner stated.					
	To To I	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)		
,			Cu Ath, Ms	10053051	M	1AR 20 2008		
	12x1		30. Name and address of person who completed cause of death (Item 23a) (The Walter Atha, MD, 10632 Little Patur		6 Columb	ia MD 21044		
	Sta	ite	S4 Date filed (Month Day Voor) 2 Pagistrar's Signature		c, corunio.	La, ID ZIVII		
	Registr		MAR 2 4 2008	perti				

DHMH 17 Rev 1/2001

Registrar

State

4940 EASTERN AVENUE

32. Registrar's Signature

Ju

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjasun

BENJAMEN TU , ND

RES-000

BALTIMORE, MD

MARCH 23 , 2008

140

State Registrar

31. Date filed (Month, Day, Year), MAR 2 4

Cynthia Small un

29b. Signature and title of certifier

LYNFMA



29c. License number

D0051347

29d. Date signed (Month, Day, Year)

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 20 2008 Physician 04:00 P M Wesson Hartio Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year Jan. 14, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Jan. 219-18-5213 Ĩ926 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Baltimore Reisterstown the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12228 Dover Road 21136 USA Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Maritai Status Black, White, etc. 1 XYes 2 Now II
If Yes, Give
Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No White Specify. Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation other than "natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Caroline Hartiq William Karl Miller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16730 Dubbs Road, Sparks, Maryland Wesson H. Miller, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If Its any injury or o 03/26/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Dulaney Valley Mem. Grdn. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lic 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P this 28b. Time of 27. Manner of Death 28a, Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year! 5 Pending investigation 11 Natural 1 Yes 2 No 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

Registrar

RAYMOND A. 31. Date filed (Month, Day, Year)

MAR 24

29b. Signature and title of certifier 1 ay mind

> 7801 YORK RD, #100 TOWSON MO 21204 NZEMD 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician March 1.45 P.M Tommy L. Oliver, Sr. 2008 /Medical 4c. County of Death 4h City Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** N/A Health timore 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Min Months 66 265-69-2279 Yrs. 3/7/42 Director GA Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10b. County Baltimore 1

Yes 2

No N/A MD **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 21229 USA 4025 Frederick Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Black, White, etc. African 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🎉 No Specify. Completed by 3 Widowed 4 Divorced Americ an Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation the Driver Pages 1 and 2 should be filed wintent of Health and Mental Hygien tant; if Item 27 is marked other the jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Oliver Jack Oliver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Clendenine St., Balt., MD 21217 Albertine Oliver/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any Injury or once. Baltimore, MD 3/25/08 Bayview Crem 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Funeral Service I censee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 20 minutes **Physician** Acute myocardial infacchion disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending f IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably Yunknown Completed emgestive heart failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 2□ No dinbetes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 1 ☐ Yes P e Hospital or Attending Ph 24 hours after death. Funeral Director: After th 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manper of Death 28b. Time of 28c. Injury at Work? Certification: Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier much 16, 2008 617916755 MD

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Pay, Year) MAR 2 4 2008

meghan

Checkley 32. Signature

900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South laton

Avenue

Bullimme, Maryland 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 20 2008 **Physician** 3:15 P M Ε. Puckett Garv /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena Anne Arundel County 8040 Woodholme Circle 8. Date of Birth July 27, 1947 North Carolina 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F 212-46-0845 Yrs. 60 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. tem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Pasadena Marvland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 8040 Woodholme Circle USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) The Baltimore Sun Pressroom Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Mitchell Otis Puckett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. (Wife) Denise Y. Puckett 8040 Woodholme Circle, Pasadena, Md. 21122 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 3/24/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licensee Kevin E Ecker 22 Name and Address of Facility McCully-Polyniak Funeral Home, 3204 Mountain Rd., Pasadena, M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 22 months METASTATIC UNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infrinciple cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner Examir be executed burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as t the attending posterior IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I cate has been signed by the a page 2 should be detached 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No 2200 1 ☐ Yes certificate Physiclan: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ဥ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (XNatural 2 ☐ Accident 5 Pending investigation .al or Atter...
.us after death.
.neral Director: A' M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16354

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAGNES

Year)

**ORIGINAL** 

900 CATON AVE BALTIMORE MD 21229

08-02113

Please Type or Print in Black Indelible on k4 Fartyre All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Wesley Reeu		- For State elegistrar	Certificate of		Reg	No. 200	8 0929
Physician		1. Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death
Medical Examine		WESLEY REED III			March 15, 2	008	2329 hrs
The same	4	4a. Facility Name (if not institution, give street and number) 76 Liberty Street		4b. City, Town, or Location of Aberdeen		4c. County of Death Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 213-42-4802 1XXM 2 F	yrs. last birthday) 64 Yrs	Months Days Hours	8. Date of Birth Min. 07/12/1	Foreig	thplace (State or In MARYLAND untry)
	ī	Usual Residence of Decedent	Olt. T	tion			10d. Inside City Limits
Maryland 28a-f show any d atonce.		10a. State 10b. County 10c.  MARYLAND HARFORD CO	. City, Town or Loca ABEF	tion RDEEN			1 Yes 2 XXNo
the Maryland a or 28a-f sh		10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cour	ntry?
the M	5	76 LIBERTY ST.		21001		U.S.A.	
h with	runerai  -	11. Marital Status 12. Was Decedent Ever	rin U.S. 13. W	as Decedent of Hispanic Ori Yes, specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ameri White, etc.	ican Indian, Black,
		1 Yes 2	No 1	Yes 2X No specify:		Specify: P	BLACK
ours after all attural"	3	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Decede	nt's Usual Occupation (Give	kind of work done	16b. Kind of Business/	Industry
6 72 hc cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		-	use retired)		
withir within her th		12th grade 17. Father's Name (First, Middle, Last)	LAB(		r's Name (First, Middle, M	BALTIMORE aiden Surname)	CO.
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	اه	WESLEY REED JR.			MA REED	-,	
212 ould be d Ments s mark lic even	֝   מ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailir	ng Address (Street and Nur		per, City or Town, State	e, Zip Code)
MD and 2 sho alth and m 27 is sumati		Ruth McDuffie/Sister	8624	Saxon Circl		Maryland	1 21236
ore, se lam of Heal		20a. Method of Disposition  1XX Burial 2 Cremation 3 Removal from State	20b. Place of Dispo crematory or o	sition (Name of cemetery, ther place)	Date	zuc. Location - City of	rown, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify:	GARRISON		03-21-08		LIS, MARYLAN
Balt permit. Depart Impor		21. Signature of Funeral Service Licensee	22   32   32	Name and Address of Facilit 1 C BROWN COM 21 S PHILA. B	MUNITY FUNEF LVD., ABERDE	RAL HOME-HA	ARFORD, P.A.
Physician	1	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter	the mode of dying, such as	cardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Medical. *xaminer		Immediate Cause (Final disease a. Cirrhosis of I					Death
Kaiimei	- 1	or condition resulting in death)  Due to (or as a conseque	ence of):				
	aller	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ence of):				
nd ned M	ي	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence d.	ence of):				
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68760, certificate be nding physic see as the bur		IF FEMALE: 23b. Was decedent pregnant in the		etal death 3 Ectop	ic pregnancy	23d. Date of delive Month	ry Day Year
Box 687  c death certific  the attending p  ed for use as th	Physician/	past 12 months?		Other (Specify)			
. Bo he dea y the a	ڇَا	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause given in F	Part I. 23e. Did to	bacco use contribute to	o the cause of death?
P.O. s that the gened by e detact	ব	Part II. Other significant conditions	t to to so tang in and	, c., c., c., c., c., c., c., c., c., c.		2 No 3 Pro	obably 4 Unknown
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n: The or, pa		25. Was case referred to medical		26.Place of Death	n (Check only one)		
Vita ysicia ysicia direct	o Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Other		Residence 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. is or Attending Physician: The law requires that it is after death.  In Director: After this certificate has been signed by the tuneral director, page 2 should be detact	Certification: To	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time o	f Injury 28c. Injury at Wo	_	now injury occurred	
Jivision Il or Attend Il or Attend Il Director:	rifica	Suicide Could not be determined (Specific)	- At home, farm, str	eet, factory, office building,	etc. 28f. Location (S or Town, S		Rural Route Number, City
P File bon		4   Homicide   Capture   C	nowledge, death occ	surred at the time, date and plantion, in my opinion, death of	place, and due to the caus	e(s) and manner as sta	ated. the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier	ation and/or investig	29c. License numbe		29d. Date signed (M	
	2	Wouvre Melhea		O.C.M.E.		March 16, 2008	
		30. Name and address of person who completed cause of deat Margarita Korell MD. Assistant Medical Ex		Penn Street, Baltimo	re, MD 21201		
Sta	17.4	31. Date filed (Month, Day, Year)  AR 2 4 2008	Signature	di)		OCME	
Registr DHMH 17 Rev 1/200		MAIN A Z ZOOO	ORIGIN	ΔΙ			
DI 11111 17 11 EV 17200	J 1		CIVIOIIA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March 18,2008 **Physician** 04:07 A M Frank D. Rettaliata /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year March 6, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 65 1943 215-42-5145 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should te filed within 72 hours after death with the Marylan Department of Health and Men al Hygiene. Important: If item 27 is market other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at angles. 1 ☐ Yes 2 X No Director Baltimore Cockevsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 35 Silversage Ct. 21030 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1966–72 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Systems Program Analyst Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Rettaliata Kathleen Battye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan S. Rettaliata / Wife 35 Silversage Ct. Baltimore, MD 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1**X** Burial 2 ☐ Cremation 3 Removal from State 3/26/2008 Parkwood Cemeterv Baltimore, MD 4 Donation 5 Other (Specify) 21. Signa re Funeral S with Licensee 22. Name and Address of Facility 5305 Harford Rd. Kimberly Davidson Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner du to multiple Mychem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2No 3 Probably 4 Unknown 1 TYes cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No certificate has performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: hours after deat uneral Director: within 24 hours a 0

> State Registrar

Medical

29a. Certifier

(Check only one)

KHAWAJA 31. Date filed (Month, Day, Year) MAR 24

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAROD

and manner stated.

6701 N-charles St., Baltimore, MD 21204 32. Registrar's Signature

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064651

29d. Date signed (Month, Day, Year)

200 3

# **Funeral** Director

Certificate of Death Reg. No. 🥬 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19, Day 2008 ear **Physician** March 10:00Pm Gerard John Reiss /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Lorien Frankford Nursing Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours 12/04/1924 ear) 216-18-9602 1 M 2 □ F 83 Mary Pand Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 X Yes 2 □ No N/A Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5209 Barbara Avenue 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) 12 Master Mechanic Manufactoring Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Reiss Lillian Stetter ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Veronica I. Reiss:- Wife 5209 Barbara Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cemetery 03/22/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) 5305 Harford Road 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21214 Approximate Interval Between Onset and Death **Physician** ntestro disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-transi attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an page 2 s has autopsy perform 2 No 1 ☐ Yes To the Hospital or Attending Physician: after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes 2 ER/Outpatient 3 DOA 2 1 Inpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be within 24 hours after dea To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 10 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

			State of State amend #29d Per Phy G	Marylan 3 <b>773/2</b> 4	d / Depa 4/08	ntment of H <i>h</i> <i>tificate of L</i>	ealth and D <i>eath</i>	Mental Hy	gien Reg. N	e •	002	QI.
			Decedent's Name (First, Middle, Last)		_			2. Date of De	ath	T 0 0 0	3. Time of De	
	Physici /Medio		Thomas I. Rynes, Sr.					03-15-		8	800 A	M
4	Examir	er	4a. Facility Name (If not institution, give street and numb	er)		4b. City, Town, or	Location of Dea	ath	40	c. County of Death Harford		
		2,	1409 Marywood Dr  5. Social Security Number 6. Sex 7.	Age (In yrs. I	last hirthday)	Bel Air	If Under 24 Hr	s. 8. Date of Bir	th	9. Birth	nplace (State or F	Foreian
- 6	Funeral Director		217-34-6134	70	Yrs.	Months Days	Hours Mir		ay, Year	r) Cou	yland	
	trade indicated		Usual Residence of Decedent					10, 25		, , , , , , , , , , , , , , , , , , , ,		
	ryland how		10a. State 10b. County		, Town or Lo						10d. Inside City f	
	e Ma Ba-f s	Director	Maryland Harford		Fallst							Ajrio
	vith the cor 2 be no		10e. Street and Number			10f. Zip Code				itizen of What Cou	intry?	
	sath v	eral	2504 Roy Terrace  11. Marital Status 12. Was Decede	ent Ever in U	S 13	21047 Was Decedent of Hi	isnanic Origin?	(Snecify Yes or No		S.A. 14. Race - Amer	ican Indian,	
40	fter d	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, Give	es? □ No		Was Decedent of Hi If Yes, specify Cuba		erto Rican, etc.)		Black, White		
036	ursa al', o		3 Widowed 4 □ Divorced If Yes, Give Year or Date	s:	,	1 ☐ Yes 2X No	Specify:			Specify: Wh:	ite	
2-0	72 ho 'natul dical	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of w	vorking	16b.	Kind of Business/I	ndustry	
22	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	Completed by	Elementary/Secondary (0-12) College (1-4	or 5+)	Engin		9		Co	mputer Co	ompany	
22	filled v Hygie ther t		17. Father's Name (First, Middle, Last)		28		18. Mother's N	ame (First, Middle			1 7	
an	d be ental	To Be	Thomas Rynes				Eliza	abeth Mat	ous	ek		
	shoul nd M	F	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Address (Street	and Number or	Rural Route Numb	er, City	or Town, State, Z	ip Code)	
SE	and 2 alth a 27 is	1	Carol A. Giese (Daughter)			Red Pump						
OMMAS more, M	of He of He fitem	П	20a. Method of Disposition  X☐ Burial 2 ☐ Cremation 3 ☐ Removal from St	20b. P	Place of Dispo emetery, cre	osition (Name of matory or other place	re)	Date	1	Location - City or		
S in	Pages ment of ant: If its		4 □ Donation 5 □ Other (Specify)	Hig		Mem. Gar.		18-2008	Fa:	llston, N	1aryland	
Thomas Rynes Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	/		2. Name and Addres		Schimunek nail Rd E	Fu Bel	neral Ho Air, MD	me of Be 21014	:lAir
			23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death	h. Do not en	ter the mode of dyin	ng, such as card	liac or respiratory	arrest,		Approximate Interval Betwee Onset and De	een
	Physician		Immediate Cause (Final disease or condition resulting in death)	P	ruc	reat	uc_	CA			M	05
	/Medical Examiner		Due to (or	as a consequ	uence of):						·	
	LAdminer	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Due to (or	as a consequ	uence of):							
	nsit ited	ni L	Cause (Disease or injury that initiated events									
ć	ficate be executed physician and streets the burial-transit	Examiner		as a conseq	uence of):							
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200	± 0, α	Med	IF FEMALE:				.07			37	-	
Box	ires that the death certific signed by the attending pl d be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 mophs?	me prpregna h 2 □ Feta htattime of d	aldeath 3	☐Ectopic pregnancy	/			23d. Date of del Month		ear
S O.		ysic	1  Yes 2  No 4  Pregnal 9  Unknown 9  Unknown		ieaiii Ji							
<u> </u>	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to dea	th but not res	ulting in the ι	underlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute to	the cause of de	ath?
rds	quires en sign uld be	ed by						1	Yes	2 <b>□ 1</b> 10 3 □ Pr	obably 4 □Ur	nknown
900	> 0 50	Completed						24a. Wa	s an opsy	24b. Were au	topsy findings av	vailable use of
Ä	ding Physician: The lav n. After this certificate has f.neral director, page 2	Com						per 1□ Yes	formed?	death?		
/ita	clan: ertific ector,	Be (	25. Was case referred to medical examiner?			oth Oth		Death Check onl	one	N. Dru	hteso.	_
٥.	Physician: this certificral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inj		ER/Outpatie	MIL 3 DOA	4 LI Nursin	g Home 5 ☐ Res 28d. Describe			bify) LCS	sidence
E	ding /	ion	1 Natural 5 Pending (Month)	Day Year)	Injury	Wor	k? Yes 2 □ No	200. 200020	, 11011 111	,u., 000000		
Division or Vital Records,	Attending rideath.	fical	3 Suicide 6 Could not be 28e, Place of	f injury - At ho	ome, farm, st	treet, factory, office		28f. Location City or To		and Number or Ru	ural Route Numb	per,
i d	s a el	Serti	4   Horricide Duilding	j, etc. ( <i>Specii</i>				Ony or 11	JW11, OI			
	To the Hospital or Attendia within 24 hours a er death. To the Funeral Director: A completely filled in by the f.	Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner and manner.	is of examina	owledge, dea ation and/or i	th occurred at the ti nvestigation, in my o	me, date and pl opinion, death o	ace, and due to the ccurred at the time	e cause e, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)	i
	To the within To the Comple	Me	29b. Signature and title of gertifier			29c. Licens	se number	1	29d. l	Date signed (Mont	h, Day, Year)	
			▶ #////W			D003	かしんと	T	M	arch 17,	2008	
	. 10		30. Name and address of certal who completed cause	of death (Iter	n 23a) (Type	Print)	11/2 /1	202	T	11/00	11071	JNL
			31. Date filed (Month/Day, Year) 32. Re	trar's Signa	ature (	July Dr	IVE, TO	2002	10	WSUIL	NUX	LUT
	St Regist	ate rar	MAR 2 1 2008	Colum	K,	Sperke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) Month  $P^{M}$ March 19, 2008 3:00 Sepe Guido 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Greater Baltimore Medical Center Towson Baltimore Birthplace (State or Foreign Country) 3. Date of Birth (Month, Day, Year) June 25, 1 If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Min. Days Hours Months 1 XM 2 ☐ F 81 1926 Italy 218-36-2551 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Cockeysville Baltimore 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21030 5 Shaston Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tailor Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosaria Spagnola Gerardo Sepe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Shaston Ct. Cockeysville, Md. 21030 Mrs. Lucia Sepe/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (Specifentombment 3-25-08 Timonium, Md. Dulaney Valley Mem. 22. Name and Address of Facility 21. Signature of Funeral Service License Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complical the that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each light Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hronic 09 Due to (or as a consequence of): So use titally list conclitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery cedent pregnant 3 ☐Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2/1/10 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 26. Place of Death (Check only one, 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No # Impatient 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury

Physician /Medical Examiner that the death certificate be executed

Physician

/Medical

10a State

Md.

Examiner

**Funeral** 

Director

r 28a-f shov notified at

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Examiner

the Medical

1 and 2 should be filed within Maryland 2121

Pages ₽

permit.

Baltimore,

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician;

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and Mental Hygiene.

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If item 27 or other tra

Director

Funeral

Completed by

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Examiner physician and s the burial-transit Physician/Medical as attending properties for use as ed by the a detached i sign**e**d to 2 should t Completed has e 2 page director, To Be within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral Certification:

IF FE	EMA	LE:
23b.	Was	de

in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner? 1 ☐ Yes

27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident

investigation 6 ☐ Could not be determined

28b. Time of (Month, Day Year) Injury

28c. Injury at Work? M

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Medical

State

Registrar

3 ☐ Suicide

4 ☐ Homicide

curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and I

4

29c. License number

29d. Date signed (Month, Day, Year)

ass of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** V2n MC12C 20 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number r 1 Year If Under 24 8. Date of Birth (Month, Day, Year)
March 28, 1923 9. Birthplace (State or Foreign Country) Kentucky Age (In yrs. last birthday) Sex / Funeral Months Days Hours 84 407-18-7091 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ia or 28a-f show t be notified at 10a State 10h Counts 1 ☐ Yes XXNo Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 U.S.A. 200 Embleton Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo If Yes, Give Year or Dates: WW TT Specify Specify: White þ XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Ova Wesley Sullivan Flora (Bush) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 200 Embleton Rd. Owings Mills, MD 21117 Alice Jean Plitt / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3/21/08 Metro Crematory Inc. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licen 11605 Reisterstown Rd. Owings Mills, MD21117 cash 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dhy Mphic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Month Year 5 Other (specify) ☐ Yes 2☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records. ð 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 Tes 2 🗆 No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

MAR 2 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 2. Date of Death 1 Decedent's Name (First Middle Last) Day **Physician** 1644 AM elen 10/501 2008 March 14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Randallston Baltimore Novethwest If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1□M 2√FF 81 229-28-1367 Director 3-12-1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Pikesville Baltimore MD 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 4204 Old Milford Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 禁 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married African-American 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Damestic Homemaker 3rd 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Blum Gaines John R. Gaines ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorinda Tolson/Daughter 9425 Joleon Road, Randallstown, MD 21133 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State King Park 3/24/2008 Woodlawn, MD 4 □ Donation 5 □ Other (Specify) 21. Signatural f Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home of Balto. Co. 9200 Liberty Rd. Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Athenosclevotic /Medical Due to (or as a consequence of): Examiner 14 Due to foras a consequence of): Sequentism list our differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as consequence of): attending physician and for use as the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Was an autopsy performed?
Yes 2 No page 2 this certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examirier: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in my principles and the cause of examiners and the cause of examiners are called the cause of examiners. 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 146055644

29d. Date signed (Month, Day, Year) March 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yorke DO Jenniterz

5401 Old Coast Rand Randallstown MD

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 2 4 2008



			For State	State of M		d / Depa		t of H	lealth a			/gien	9	. 0	0020	nΩ
-		-	Registrar  1. Decedent's Name (First, Middle, Las.	4)		061	imeate	01 1	Dealli		2. Date of De	Reg. No	2' 1	10	3. Time of Do	J ()
	Physi	cian	1. Decedent's Name (First, Middle, Last	,							Month	Da		Year		
	/Med Exam		MARY CATHER II  4a. Facility Name (If not institution, give				4b. City,	Town, or	r Location o		March	20	20 c. County o	08 of Death	0425	М
			GILCHRIST HOSPICE	E			TOW	SON					BALT	IMOR	E	
	Funera	1	Social Security Number     6. Se	ex 7. A □ M 2 X F	ge (In yrs. I	ast birthday)	If Under Months	1 Year_ Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year	)	9. Birthp	lace (State or F htry)	Foreign
	Directo		217-20-1610 Usual Residence of Decedent	LIN ZLAI		8 Yrs.					AUG.	3, 1			YLAND	
8	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City	Limits
BI	Maryland -f show	ğ	MARYLAND BALT	TIMORE		RΔ	LTIMO	DE.							1 ☐ Yes 2	ĭŽ No
Kureh 20,2008	with the last or 28a-	Funeral Director	10e. Street and Number	11101(1		D1.	10f. Zip					10g. C	tizen of W	hat Cour	ntry?	
2	3a o		619 WAMPLER ROAI	D				213	220				U.S.	Δ.		
10	death ms 23gr	Jer	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.	S. 13.1	Was Deced			gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race	- Americ	an Indian,	
₹,	or ite	교	1 ☐ Never Married 2X Married	Armed Forces 1 ☐ Yes 2 🛭 If Yes, Give	) <b>X</b> o						Rican, etc.)			, White,		
== 8	al", c	b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	:		1 ☐ Yes 2	Z No	Specity:				Specify:	BLAC	!K	
\$ 00-15 5-00-36	72 hc 'natu	Completed by	15. Decedent's Edu (Specify only highest grad	ucation de completed)		16a. Deced	dent's Usua	l Occup	ation	t of workin	aa	16b. l	Kind of Bus	siness/In	dustry	
32	ithin an "	ld u	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wor DO NOT us	e retired	3)		9	BA	LTIMO	RE C	ITY SCH	HOOLS
22	ygier t, the	Š	llth grade			CAFE	ETERIA	MAN				1				
<i>∞</i> <u>F</u>	should be fled w and Mental   ygie s marked o her t umatic ever t, th	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	e, Maide	n Surname	∍)		
3 = 2	ould Men larke	은	unknown			1	-				SUMMERY					
Maryland	ges 1 and 2 should be fled within 72 hours after death with the Marylar to of Health and Mental "yojene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic evert, the Medical Exeminer must be notified at		19a. Informant's Name/Relationship (T	ype. Print)		19b. Mailir	ng Address	(Street	and Numbe	er or Rura	l Route Numi	ber, City	or Town, S	State, Zip	Code)	
7	l and fealth im 27		Pastor Edward Whit	te Sr./Hu		619 lace of Dispo			Rd.,		imore					
3	Pages 1 nent of 1- nt: If ite		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 ☐ I			emetery, crei	matory or of	ther plac	ce)	Di	ale	200. 1	ocation - (	onty or 10	wn, State	
3	tmen tant:		4 Donation 5 Other (Specify		Ebe	nezer				03-29					MARYLA	
Mayor Ca	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signal are of Funeral Service Ligens	see		WM.	2. Name and I C BR	d Addres	ss of Facilit COMM	У Т Т Т Т Т	FUNE	RAL :	HOME-	HARF	ORD, P.	Α.
	00200	12 0	Carrina Com	run	al disas also di	3	<u> 321 S</u>	PHII	LADEL]	PHIA	BLVD.	, AB	ERDEE	N, M	D 21001	
- 1		8 6	23a. Part1. Enter the disease, or comp shock, or heart failure. List only compared to the comp	//		n. Do not ent	er the mode	e or ayın	ig, such as	cardiac oi	r respiratory a	arrest,			Approximate Interval Betwe Onset and De	en ath
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. 1910		Coma	W							V	untus	
	/Medica Examine		Toolaning in double)	Due to (or as	s a consequ	uence of):										
		<u>~</u>	Sequentially list conditions,	b. Due to (or as	s a consequ	uence of):								-		
,0	rted	Ę.	Sequentially list conditions, if any, leading to immediate cause. Ener Undership Cause (Disease or injury	`												
12	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	s a consequ	uence of):										-
760	te be ey ysician ie burial	cal		.d.												
89	Seath certificate to attending physical for use as the b															
Box	h cer endin	N/N	23b. was decedent pregnant	23c. If yes, outcome			∃Ectopic pre	agnancy	,				23d. Date	of delive	,	
	deat death	ici Sici	in the past 12ymonths? 1 ☐ Yes 2 ☐ No	4□Pregnant a			Other (sp						Mon	ith	Day Ye	ar
PO	at the by th	Physician/Medi	9 Unknown	9LI UNKNOWN			-				S					
V.	The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	by F	Part II. Other significant conditions co	ontributing to death	but not resu	ılting in the u	nderlying ca	ause give	en in Part I.						ne cause of dea	
ord	equir sen si ould					****					1	Yes 2	No No	3 Prob	ably 4 ∐Uni	known
5	law las be	Completed									24a. Was	opsv	D	Vere auto	psy findings av	ailable se of
<u> </u>	sician; The law certificate has b irector, page 2 s	S P									perl 1∐ Yes	ormed? 2. <b>Y</b> N	o 1	eath? □Yes		
it a	cian; ertiflic ctor,	Be (	25. Was case referred to medical examiner?							of Death	(Check only	one)				
7	Physi this c	ျ	T res 2 No			ER/Outpatier			4 ⊔ Nu						nospu	e
2	ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D		28b. Time of Injury		8c. Injur Worl			8d. Describe	how inju	ary occurre	ed		
Sic	tend leath tor:	cati	2 Accident Investigation 3 Suicide 6 Could not be	One Plans of in	At ho	mo form str	M		Yes 2			/O: .	101 1		10 11 1	
Division or Vital Records	or Attending Physician; after death. Director: After this certifica I in by the funeral director, I	Certification:	4 ☐ Homicide determined	20e. Flace of fi	etc. <i>(Specif</i> y	me, rarm, str /)	eet, factory	, orrice		2	8f. Location City or To			er or Rura	al Route Numbe	er,
	pital ours a leral   filled		29a. Certifier Certifying Phy	ysician: To the bes	t of my kno	wledge, deat	h occurred :	at the tir	me date an	nd place a	and due to the	e cause/	s) and mar	nner as s	tated	
(1)	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exam	iner: On the basis and manner s	of examinat	tion and/or in	vestigation,	in my o	pinion, dea	ath occurre	ed at the time	e, date a	nd place, a	ind due t	the cause(s)	
	To the vithin to the complex c	Me	29b. Signature and title of certifier				290	. License	e number						Day, Year)	
Ŏ	1-21-0		* Whal	r Vm				) (	583	03		M	wit .	20 0	3058	
	3		30. Name and address of person who c	completed cause of	death (Item	23а) (Туре,	Print)	_					rat.			
_	.2	11.3	Amon 2. Char		6701	N. Cl	rents	ST	Ton	50~ 1	W) 2	126	4			
	S Regis	tate trar	31. Date filed (Month, Day, Year) MAR 2 4 200	8 . Regist	trar's Signa	23a) (Type,	de									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 16006 2005 EVED /Medical Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Herbac HOS A, to BEHIMOR If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) Sept 20, 1 9. Birthplace (State or Foreign Country)
N. Carolina 5. Social Security Number 7. Age (In yrs. last birthday Days Hours 1 X M 2 ☐ F 35 217-94-6636 1972 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 TYes 2TX No Director Anne Arundel Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 586 Terrace View Avenue 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 X No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Power Scape Co. Power Washer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benson O. Yeaney Terry Lynn Keefe ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Terry Lynn Volkman (Mother) 586 Terrace View Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21 Signature of June 12 ervice Licensee <sup>22</sup> Name and Address of Facility McCully-Polyniak Funeral Home, P. 237 E. Patapsco Ave., Balto., Md. Keyin E Ecker 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -Vhd Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical **Examiner** 

attending physician

the

for use

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signed by t

has page 2

certificate Physician:

this

After t

or Attending

Hospital

death.

hin 24 hours after death the Funeral Director:

funeral director.

the

filled in by

completely

2

Physician/Medical

2

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other transactions.

Examiner burial-transi

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

Due to (or as a consequence of)

4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

3 □ Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Year

1 Inpatient 2 ER/Outpatient 3 DOA

autopsy performed! res 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No

1 ☐ Yes 2 ☑ No 27. Manner of Death

5 Pending investigation 2 Accident 6 Could not be 3 Suicide 4 ☐ Homicide

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

28c. Injury at Work?

29b. Signature and title of certifier

2005

29d. Date signed (Month, Day, Year)

State

Michael 31. Date filed (Month, Day, Year) MAR 2 4 2008

MINON 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	State of Mary	-	artment of F rtificate of			ene2 () (	09300
į	Physici /Medi		1. Decedent's Name (First, Middle, La	toung				2. Date of Death	Day 20	3. Time of Death
	Examir		4a Facility Name (If not institution, give Baltimore Washin	inton Medical		Glen	Location of Death		4c. County of	Arundel
ľ	Funeral Director		5. Social Security Number 6. S 579–50–9270  Usual Residence of Decedent	5ex 1 M 2 ☐ F 7. Age (In 76	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Yea <i>r)</i> 1931	Birthplace (State or Foreign Country)     Hawaii
	the Maryland 28a-f show notified at	rector	10a. State 10b. County  Maryland Anne Ar  10e. Street and Number		Glen Bur			10	g. Citizen of W	10d. Inside City Limits 1
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show hipportant; If item 27 is marked other than "attempt or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	103 Oak Srpings I  11. Marital Status  1 □ Never Married 2X Married	Prive  12. Was Decedent Ever Agned Forces? 1 ∑ Yes 2 □ No If Yes, Give		210	060  Hispanic Origin? (Span, Mexican, Puerto		14. Race Black	.S.A. - American Indian, , White, etc.
21215-0036	thin 72 hours e.e. an "natural", c	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr.	Year or Dates:	16a. Dece	dent's Usual Occup	pation during most of work	sing 1	Specify: 6b. Kind of Bus	White
Maryland 21	ould be filed withi Mental Hygiene. arked other than atic event, the M	To Be Con	12 17. Father's Name (First, Middle, Last Henry	N/A	Medi Your	cal Dist		e (First, Middle, M a Haua		
	es 1 and 2 should of Health and Men fitem 27 is marken or other traumatic		19a. Informant's Name/Relationship ( Shirley J. Young  20a. Method of Disposition 1 Burial 2 X Cremation 3 D	(Wife)	103	Oak Spr		ral Route Number, e Glen Bu	City or Town, S urnie, N	State, Zip Code)  Maryland 21060 City or Town, State
Baltimore,	permit. Pages Department of I Important: If ite any Injury or or once.		4 Donation 5 Other (Special Signature of Funeral Service Lice	fy)	2 N	Crematory 2. Name and Addre IcCully-Po 3204 Mount	<u> </u>	uneral Ho	ome. P.A	re, Maryland A. land 21122
	Physician /Medical		23a. Part1. Ther the disease, or com shoc., or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	$C \rightarrow X$	death. Do not en	ter the mode of dyir	ng, such as cardíac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor  Due to (or as a cor	aneous		neumoth			Imonth
68760,	ificate be executed g physician and as the burial-transit	dical			( obstro	divy lu-	ny dream	ψ		Years
P.O. Box	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc	у		23d. Date Mon	e of delivery nth Day Year
	requires that een signed b hould be deta	ted by Pr	Part II. Other significant conditions	contributing to death but no	t resulting in the u	inderlying cause giv	ven in Part I.	1 ₱ Yes	s 2□No	ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Division or Vital Records,	The la	Be Completed	25. Was case referred to medical				26. Place of Dea	24a. Was an autopsy perform  1 Yes 2	ned? di	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
<u>_</u>	≥ .º 0	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatient	2 ER/Outpatie	nt 3 DOA Oth	ner: 4 🗆 Nursing H	ome 5 ☐ Resider	nce 6 🗆 Othe	er (Specify)
ision o	dling After fune	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide  6 Could not be			M 1 □	ryat rk? ∣Yes 2 □ No	28d. Describe how	,	ed er or Rural Route Number,
Div	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined  29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	28e. Place of injury building, etc. (S)  hysician: To the best of my miner: On the basis of exa	y knowledge, dea	th occurred at the ti	me, date and place	City or Town,	State) use(s) and mar	nner as stated.
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29b. Signature and file of certifier	and manner stated.	- MY	29c. Licens				(Month, Day, Year)
	5		30. Name and address of person who					m Burni	u ,mn	2106
	St	ate	<ol> <li>Date filed (Month, Day, Year)</li> </ol>	32 egistrar's 5	signature	41.				

DHMH 17 Rev 1/2001

Registrar

MAR 2 4 2008

Registrar

State

AMANDER 31. Date filed (Month, Day, Year) MAR 2 4

f person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

10063322

ROAD, PANDALLS TOWN, MD

State of Maryland / Department of Health and Mental Hygiené / [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 2008 6:45 AM Auchincloss Marian Lee /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown 12126 Heather Drive Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 1, 1935 9. Birthplace (State or Foreign Mary Tand 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M **¾(X**F 73 Yrs. Director 217-30-1215 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "neturel", or items 23a or 28a-f shov The Madical Examiner must be notified at 1 ☐ Yes 2 🕱 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12126 Heather Drive 21740 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Heelth and Mental Hygiene.
Importent: If item 27 is marked other than "ne any injury or other treumetic event, Ite Muster 2006. Elementary/Secondary (0-12) College (1-4or 5+) 12 Parish Administrator Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Snyder Leo Winona Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Michael Skinner - Son</u> 138 Violet Lane Falling Waters, West Virginia 25419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory Mar. 12,2008 Smithsburg, Maryland 21. Signatura Juneval Service License Osberne Afternetterity Home, P.A. 1/4/02 425 S. Conococheague St.Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate dause (Final disease or ondition resulting in death) Physician varboding menary minutes /Medical Due to (or as a consequence of) Examiner accineme if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 Nursing Home 5 Aesidence 6 Other (Specify) ဥ 1 ☐ Yes \_2 ☑ No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MO MD0052136 30. Name and add ress of person who completed cause of death (Item 23a) (Type, Print) Kendle Rd Williamsport MD iccarelli 16605 31. Date filed (Month Pay, 32. Resstrar's Signature State 2 2008 Registrar

			For State Registrar	State of Marylar		rtment of Ho tificate of E		Mental Hy	giene Reg. No2 (	308	09300
40.4	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Mary C. Bland					2. Date of De Month March	Day 4 • 200	Year	3. Time of Death 6:22 A
	Examir		4a. Facility Name (If not institution, give st Springbrook Nursing			4b. City, Town, or Silver Sp				nty of Death	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da October	rth ay, Year)	9. Birthplac	ce (State or Foreign
	Đ		Usual Residence of Decedent	100 68	ty, Town or Loc	ation		фесовег	J,172.		
	//aryla f shov ed at	o	D.C. 10b. County N/A		hingtor					100	<ol> <li>Inside City Limits</li> <li>1 XYes 2 No</li> </ol>
	r 28a-	irect	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Country	?
	ath with 23a o ust be	ralD	5049 - 11th Street,	NE		20017			United	d State	s
036	ours after deg ai", or items Examiner m	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Morital Status	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2  No If Yes, Give Year or Dates:</li> </ol>	If	as Decedent of His Yes, specify Cubar □ Yes 2 <b>□X</b> No	spanic Origin? (Sp n, Mexican, Puerto Specity:	pecify Yes or No Rican, etc.)	В	lace - American lack, White, etc Co-Amer city:	C.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)	(Give k	ent's Usual Occupa ind of work done di O NOT use retired) ecretary	uring most of work			Business/Indus	
b	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Surn	ame)	
ylai	should band Ments marked	70 8	Isiah Casper		· <del>1</del> · · ·		Florence				
Mar	id 2 sh Ith and 17 is m traum		19a. Informant's Name/Relationship (Type Bernita B. Smith/d			Address (Street a					
more,	Pages 1 and intention of Health Int: If item 27 Iny or other tr		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State Mar	Place of Dispos			Date / 2008	20c. Location	n - City or Towr	
Salti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licenses	8 10.8.	I	Name and Address					
	<u> </u>		23a Part 1 Enter the disease or complice	ations that caused the deat		00 Georgi					pproximate
	Physician /Medical Examiner		23a. art1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Coronary  Due to (or as a conseq	Artery			- Toophutory c		l r	nterval Between Onset and Death
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertring Cause (Disease or Injury that initiated events.	Due to (or as a conseq	juence of):						
68760,	fficate be executed g physician and ss the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conseq	ruence of):						
P.O. Box (	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (X) No 9 □ Unknown	c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 🗆	Ectopic pregnancy Other (specify)			10.	Date of delivery Month Da	ay Year
Vital Records, P	luires that n signed b	by	Part II. Other significant conditions control End Stage Renal I		ulting in the und	lerlying cause give	n in Part I.				cause of death?
ဂ္ဂ	law require as been si 2 should b	Completed	Diabetes Mellitus	s Type 2				24a. Was	an 24	b. Were autops	y findings available
ř	@ 0	E O	Hypertension					auto perfe 1⊟ Yes	psy ormed? 2 <b>X</b> INo	death?	letion of cause of □ No
VII a	i <b>lcian:</b> Th certificate ector, pag	Be	25. Was case referred to medical examiner?	spital:		Othor	26. Place of Deat				
ō	Phys r this eral dir	2	1 ☐ Yes 2 No Ho  27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA Other	4 LA Nursing Ho	ome 5 ☐ Resi 28d. Describe			
Ö	inding lath. r: After e funer	ation	1 A Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		es 2 □ No			arrod	
DIVISION	tal or Attending Physician: rs after death. ral Director: After this certificied in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	(y)			City or To	wn, State)	mber or Rural F	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one)  Certifying Physic 2  Medical Examine	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death ation and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the rred at the time	cause(s) and date and plac	manner as state e, and due to the	ed. ne cause(s)
	To the within to the complex c	Ž	29b. Signature and title of certifier	0 /	7	29c. License			29d. Date sign	ned (Month, Da	y, Year)
1	0	-	30. Name and address of person who com	Aegal	1 23a) (Typy, P	D5226	1		March !	5, 2008	
			Alan R. Segal, M.I				Spring,	Maryla	and 209	06	
Į,	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signa		<b>1</b> 8					

DHMH 17 Rev 1/2001

		1 - For State Registrar			epartment of Health and Certificate of Death	morna, ri	Reg. No.	008	09304				
	₹.	Decedent's Name (First, Middentification)	dle, Last)			2. Date of D	eath		3. Time of Death				
Physici /Medi		Mary Elizab	eth Bridges			March	6, 2008	Year B	4:50 <sup>P<sub>M</sub></sup>				
Examir		4a. Facility Name (If not institution	on, give street and numbe	r)	4b. City, Town, or Location of De	ath	4c. Cour	nty of Death					
		Brooke Grove	Nursing Hon	ne	Sandy Spring			ntgome	ry				
Funeral Director		5. Social Security Number 213-54-8806	6. Sex 1 ☐ M <b>2XX</b> F	Age (In yrs. last birth	Months   Davs   Hours   Mi	n. (Month, E	irth ay, Year) 9, 1910	Coun	lace (State or Foreign htry) ucky				
and t		Usual Residence of Decedent  10a. State 10b. Count	ty	10c. City, Town	or Location			1	0d. Inside City Limits				
Mary f sho	ō	Maryland	Montgomery	, Sil	ver Spring				1 ☐ Yes 2 ☐ No				
r 28a	Director	10e. Street and Number	Honegomery	, , , ,	10f. Zip Code		10g. Citizen o	of What Coun	itry?				
h with	a D	15101 Interla	chen Drive		20906		US.	A					
deat	Funeral	11. Marital Status	12. Was Deceder Armed Forces		13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or N		ace - Americ					
after or ite mine		1 ☐ Never Married 2 ☐ Ma	arried 1 Yes 2	Í No	1 ☐ Yes 2 ☐ No Specify:	eno mican, etc.)		lack, White,	•				
iours iral", Exa	d by	3 Nidowed 4 Divorce	ed Year or Dates					cifWhite					
72 h "natu	ete		ent's Education nest grade completed)	1 (	lecedent's Usual Occupation Give kind of work done during most of w ife. DO NOT use retired)	orking	16b. Kind of	ind of Business/Industry					
withir ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	,	0	TT						
filed Hygid		17. Father's Name (First, Middle	e, Last)		Homemaker  18. Mother's N	ame (First, Middl		Home ame)					
ld be ental ked c	To Be	Jesse J. Jarv	ri s		Anna	Mae Wrig	ht.						
shou nd M mar	-	19a. Informant's Name/Relation		19b. I	Mailing Address (Street and Number or			vп, State, Zip	Code)				
nd 2 alth a 27 Is	И.,	Jeffrey Bridg	es/Son	89	05 Eastbourne Lane	e, Laure	1, MD 2	0708					
s 1 a of Hei item othe	1 3	20a. Method of Disposition		cemetery	Disposition (Name of crematory or other place)	Date 10	20c. Location	n - City or To	wn, State				
Page hent c nt: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		te i ".	Heaven Cemetery	2008	Silver	Sprin	q, Marylan				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servic	e Licensee		22. Name and Address of Facility	Funora	l Homo	Tno					
<b>8 3 5 6</b> 8	0	Francis J. Collins Funeral Home Inc.  500 University Blvd, W, Silver Spring, MD											
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that caus st only one cause on each	ed the death. Do no	500 University Blace tenter the mode of dying, such as card	ac or respiratory	ilver Starrest,	pring.	Approximate Interval Between				
Physician		Immediate Cause (Final disease or condition			t enter the mode of dying, such as card	ac or respiratory	ilver S arrest,		Interval Between Onset and Death				
/Medical		Immediate Cause (Final	_a_Hypert		t enter the mode of dying, such as card	ac or respiratory	ilver S arrest,		Interval Between				
	_	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Hypert Due to (or a	tensive Ca as a consequence of vswal Atri	t enter the mode of dying, such as card urdiovascular Dise: : :: :: :::::::::::::::::::::::::::	ac or respiratory	ilver S	1	Interval Between Onset and Death				
/Medical Examiner	niner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Hypert Due to (or a	tensive Ca as a consequence of	t enter the mode of dying, such as card urdiovascular Dise: : :: :: :::::::::::::::::::::::::::	ac or respiratory	ilver S	1	Interval Between Onset and Death O Years				
/Medical Examiner and Intravel Intravel Intravel Intravel Interest	xamin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Hyperi Due to (or a b. Paroxy Due to (or a	tensive Ca as a consequence of vswal Atri	t enter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation	ac or respiratory	ilver S	1	Interval Between Onset and Death O Years				
/Medical Examiner and Intravel Intravel Intravel Intravel Interest	Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hyperi Due to (or a b. Paroxy Due to (or a	tensive Ca as a consequence of VSI:nal Atri as a consequence of	t enter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation	ac or respiratory	ilver S	1	Interval Between Onset and Death				
/Medical Examiner and Intravel Intravel Intravel Intravel Interest	Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hyperi Due to (or a b. Paroxy Due to (or a	tensive Ca as a consequence of VSI:nal Atri as a consequence of	t enter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation	ac or respiratory	ilver S	1	Interval Between Onset and Death				
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/Medical Examiner and Intravel Intravel Intravel Intravel Interest	Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hyperi Due to (or a b. Paroxy Due to (or a c. Due to (or a d	as a consequence of as a consequence of as a consequence of the pregnancy and present time of death	t enter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation	ac or respiratory	arrest,	1 1 Date of delive	Interval Between Onset and Death O Years  Month				
/Medical Examiner and publications of the properties of the proper	Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a. Hyperi Due to (or a b. Paroxy Due to (or a c. Due to (or a d. 23c. If yes, outcom	as a consequence of as a consequence of as a consequence of the pregnancy and present time of death	t enter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation  :  3□Ectopic pregnancy	ac or respiratory	23d. [	1 Date of delive	Interval Between Onset and Death O Years  Month  eny Day Year				
/Medical Examiner and Intravel Intravel Intravel Intravel Interest	Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	a. Hyperi Due to (or a b. Paroxy Due to (or a c. Due to (or a d.  23c. If yes, outcom 1  Live birth 4  Pregnant 9 Unknown	as a consequence of as a consequence of as a consequence of a consequence	t enter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation  :  3□Ectopic pregnancy	ac or respiratory	23d. [	Date of delive	Interval Between Onset and Death Onset and Death Onset and Death On Years  Month  Pry Day Year  The cause of death?				
/Medical Examiner and Intravel Intravel Intravel Intravel Interest	by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, ar any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	a. Hyperi Due to (or a b. Paroxy Due to (or a c. Due to (or a d.  23c. If yes, outcom 1  Live birth 4  Pregnant 9 Unknown	as a consequence of as a consequence of as a consequence of a consequence	t enter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation.  :  3□Ectopic pregnancy 5□ Other (specify)	ac or respiratory	23d. [	Date of delive	Interval Between Onset and Death O Years  Month  eny Day Year				
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hysician: The law requires that the death certificate be executed his certificate has been signed by the attending physician and indirector, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, ar any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hyperi Due to (or a b. Paroxy Due to (or a c. Due to (or a d.   23c. If yes, outcom 1  Live birth 4  Pregnant 9 Unknown tions contributing to death	as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a conseq	tenter the mode of dying, such as card  indiovascular Disc:  al Fibrillation.  3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of Datient 3 DOA	23e. Did 1	tobacco use colly yes 2 \( \text{No} \) No s an opsy formed? 2 \( \text{No} \) No one) sidence 6 \( \text{Const.} \)	Date of delivered Month  Date of delivered Month  Difference of the second death?  The second death?  The second death?	Interval Between Onset and Death Onset and Dea				
law requires that the death certificate be executed  xs been signed by the attending physician and 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of the past 12 months? 1 □ Yes 2 □ No 25. Was case referred to medic examiner? 1 □ Yes 2 □ No 27. Manner of Death 1 ☑ Natural 5 □ Pend	a. Hyperi Due to (or a b. Paroxy Due to (or a c. Due to (or a d.   23c. If yes, outcom 1   Live birth 4   Pregnant 9   Unknown tions contributing to death thospital: 1   Inpa 28a. Date of In (Month, In	as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a conseq	tenter the mode of dying, such as card  rdiovascular Dise:  al Fibrillation  :  3 Ectopic pregnancy 5 Other (specify)  he underlying cause given in Part I.  26. Place of Datient 3 DOA Other: 4 Nursing	23e. Did 1	23d. [ tobacco use co ] Yes 2 □ No s an opsy formed? 2 ☑ No	Date of delivered Month  Date of delivered Month  Difference of the second death?  The second death?  The second death?	Interval Between Onset and Death Onset and Dea				

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

Physic /Med Exam

Baltimore, Maryland 21215-0036

10

31. Date filed (Month, Day, Year) State MAR 1 0 Registrar

29b. Signature and title of certifier

29a. Certifier (Check only one)

Medical



Mis mo

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D31918

29d. Date signed (Month, Day, Year)

March 7, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 Month **Physician** March 5, Morris BLUM 3:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 19, 1910

8. Birthplace (State or Foreign Country)
New York 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 97 Director 066-09-6105 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits r 28a-f show notified at 10a. State 10b. County W Yes 2 No Maryland Montgomery Rockville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 20852 6111 Montrose Road #210 United States 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X**☐ No white Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 1 and 2 should be filed wi Health and Mental Hygien em 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Jacobs Isadore Blum 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 7923 Ivymount Terrace, Potomac, MD Anita Cohen, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/07/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance Memorial Park Clarksburg, MD 21. Signature of Paneral Service Li 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Print . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9□Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 certificate Division or Vital Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this ( 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural
2 Accident Injury in Hospital in 24 hours after death.

the Funeral Director: After in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Parameters on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01808 Vany uis-30. Name and address of person who completed cause of death (Item/23a) (Type, Print) 612, MONTRISE RO, ROCKVILLE MO 20852 MD. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 0 2008 Registrar

DHMH 17 Rev 1/2001

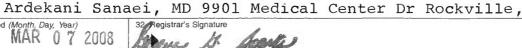
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Physician Modical Examine	"	Josue Ca	,		no Cr								Date of De Month Varch 6,		Year		ime of Death	
(" Cloud Examina		la. Facility Name (i							4b. Cit	ty, Town, or	Location o		viarch 6,		County of De			
_		Suburban H	lospital						Ве	thesda				Mo	ntgomen	/		
Funeral Director	*	5. Social Security N	n/a	6. Sex	2F	7. Age		st birthday) . 3 Yı	М	Inder 1 Year onths Days	_	Min.		8, 19	1.	Country	ce (State or For ) uras	eign
any	-	Jsual Residence of 10a. State	f Decedent 10b. County			<u> </u>	0c. City.	Town or Loca	ation							10d	I. Inside City Lin	nits
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the Maryland a or 28a-f show lifted at once.	3 -	MD 10e. Street and Nu	Montg mber	gomer	У		Gern	antow		Zip Code				10g. Citize	n of What C	ountry?		_
the M and 2		11635 Su	mmer (	ak D	rive				20	0874				Hondu	ras			
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 77 is marked other than "matural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once. To Re Commission by Eumeral Director.	חופומ	11. Marital Status  1 Never Marrie		tarried 1	2. Was Dec Armed Fo	orces?	ver in U.S	If	Yes, sp	edent of His pecify Cuban	, Mexican,	Puerto Rio	can, etc.)		White, etc		Indian, Black,	
s after ral", niner hy	3	3 Widowed		Lor	es, Give Yea Dates:		1-4			2 No					pecify:Wh			
5-0036 ed within 72 hour stygiene. other than "natu the Medical Exar		15. Decedent's Ed			College (1			16a. Decede during i		working life.				10D. KII	nd of Busine:	ss/inaus	stry	
D36 thin 7 re. than edical		6						Shoe	make	er				Sho	e Dist	rib	utor	
5-0( led wi Hygier other		17. Father's Name	(First, Middle	, Last)								•		, Maiden S	urname)			_
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica		Luis Alo						T					a Cru					
MD 21 cd 2 should dith and Me n 27 is ma aumatic ev	ٔ   ٔ	19a. Informant's Na Doris Go			e, Print)				-	,					or Town, St MD 20			
and 2 and 2 Health tem 2	-	20a. Method of Dis		LIC				lace of Dispo	osition (	Name of cer			ate		cation - City			
TOT6 ages 1 nt of H tr. If i		1 Burial 2	p		Removal fr	rom State		rematory or o			orv	03/1	0/08	Be1	tsvil	e.	MD	
Baltimore, permit. Pages 1 a Department of He Important: If ite	_	4 Donation 5 21. Signature of Fu			1	1,	Jone	-			-			1	P.O.	_		
Per Per Initial		Berry	St	He	all	H	MO 1											02
Physician / / Ledi_1	7	23a. Part I. Enter the failure. List on	ne disease, o	r complica on each	tions that c line.	aused th	ne death.	Do not enter	the mo	de of dying,	such as c	ardiac or re	spiratory a	rrest, shoc	k, or heart	A	Between Onset	rval and
kaminer		Immediate Cause ( or condition resulti		_	ad And I											1	Death	
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led nsit		Disease or injury to	that initiated	C	e to (or as a	a consec	uence of	):								+		
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Di 24 hours a Funeral I etely filled		4 Homicide		ermined				I / Highwa									, MD	
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To To COU		9b. Signature and	title of certifi		id manner s	stated.				29c. Licens	e number			29d. D	ate signed	Month,	Day, Year)	
		Drout 9	Brutho	11/	11					O.C.	M.E.			Marc	th 8, 2008	3		
A. 3-	-	30. Name and addr	ress of person							<u> </u>								
(3)0		Pamela E. S			ssistant				11 Pe	enn Stree	t, Baltim	nore, ME	21201					
Stat Registra	e 3 T	31. Date filed (Mon	MAR 1	1 20	32. Re	egistrar's	s Signatui	re M 1	Land	61								
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OCME 2006									_									

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** March 3, 2:20P M LURINE COONEY RACHEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day **Funeral** Months Days Hours Min. June 23, 1927 1 ☐ M 2 🔀 F Texas Director 523-54-5745 80 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show notified at Rockville MD Montgomery Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be ral", or items 23a Examiner must b 20851 U.S.A. 506 First Street Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐Yes 2€ No Yes, Give 1 ☐ Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", ental Hygiene. ed other than "natura e event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 12th Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 Is marked or r other traumatic eve Sarah Foreman Ceasar Davis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 First St Rockville, MD 20851 item 27 I James Cooney-Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of H Important: If ite any Injury or of once. Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem Pk 3/8/08 Rockville.MD 4 Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Line 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACRANIAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner STROKE Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an was a autopsy performed? 1∐ Yes or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident efter death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospita To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) MAR 0 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MD

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Martha Month Clarke Louise 26, 2008 4c. County of Death 0850 M Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner b+Nursing Ctr Salisburg Dicomica Year If Under 24 Hrs. 7. Age (In yrs. la 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. 1 ☐ M 2**X** F Months Hours 214-30-4052 74 9/10/1933 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? items 23a or 913 Sapphire Court 21804 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 'natural", or 1 ☐ Yes 2 No Specify: Completed by white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner Hunting Lodge Maryland ? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Elizabeth Davie Henry Edward Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any injury or other trauonce. Mary Jane Thomas/sister 13913 Sapphire Court, Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/27/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee Holloway rufferal Home Professional Association WE 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 ear-/Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ca em Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 □ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 2 4No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No neral Director; / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1381 30. Name and address of person who company (No. D. William H. Robins M. D. 32 registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

MAR 1 0 2008

200

ivic Ave.

			1- State of M	laryland / Depa	artment of F			ene 0 0	8	093	09
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month		Year	3. Time of	Death
	/Media	cal	Yong Hee Chung				MAR		800	8:21	P <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution, give street and number,	,		or Location of Dea	ath	4c. County of			
	Funeral		6235 Deep River Canyon  5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Colum		rs. 8. Date of Birth	Howar		ace (State o	or Foreign
	Director		214-02-1000	75 Yrs.	Months Days	Hours Mir	JUN 2,	Year)	Coun	try)	ii i Qreigir
	pu ,		Usual Residence of Decedent  10a, State 10b, County	140- 01- 7							
	laryła ehov	5		10c. City, Town or Lo					10	0d. Inside Ci	ity Limits 2 X No
	the M	Director	Maryland Howard  10e. Street and Number	Co1umb;				0111			
	with Sa or	Ö	6235 Deep River Canyon		10f. Zip Code	_		g. Citizen of Wh	at Coun	try?	
	ns 23	Funerai	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	2104 Was Decedent of H		Specify Yes or No-	Korea 14. Race	America	an Indian	
9	or Ite		1 Never Married 2 Married 1 Yes 2	? No	f Yes, specify Cuba	an, Mexican, Pue	erto Rican, etc.)	Black,	White, e	etc.	
933	172 hours after death with the Maryland "neturel", or Items 23a or 28e-1 ehow calcal Examiner: ust be notified at	d by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		Specify:	Asi	an	
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<u>lar</u>	ould be Mental arked c	To B	Unknown			Unknov	√n				
Maryland 21215-0036	s m		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	and Number or F	Rural Route Number,	City or Town, St	ate, Zip	Code)	
2	and salth n 27 er ti		Kyung Hee Yu/Daughter		Deansgat		Springfiel		2215		
5	Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 XRemoval from State	20b. Place of Dispo cemetery, cren National Park	sition (Name of natory or other plac Memorial	ce)	Date 2	0c. Location - C	ity or Tov	vn, State	
∄	it. Pa irtmer irtent: njury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee					alls Ch	urch	, VA	
Ba	permit. Pag Department Importent: b any Injury o		Macon	101508 Fa	nirfax Me	morial F	Funeral Ho	me	2000		
	\$ 100 m		23a. Part1. Enter the disease, or complications that cause	d the death. Do not ente			d, Fairfax		2032	Approximate	9
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68	death certificate be executed e attending physician and ed for use as the burial-transit	ledic									
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		Ectopic pregnancy			23d. Date	of deliver	у	
В	e dea he att	sicia	1 Yes 2 No 4 Pregnant at		Other (specify)			Month	n [	Day Y	/ear
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ords,	The law requires that the tee has been signed by thoage 2 should be detached.	ted by	Part II. Other significant conditions contributing to death b	ut not resulting in the un	nderlying cause giv	en in Part I.	1 Yes	cco use contrib		bly 4 🗆	
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/ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			26. Place of De	eath Check only one				
	ys Si dii	2	1 ☐ Yes 2 🏋 No Hospital: 1 ☐ Inpatie			4   Nursing	Home 5 🔀 Residen				
Division of	De ter	ertification;	27. Manner of Death  1 XNatural 5 Pending (Month, Da)  2 Accident investigation	y Year) 28b. Time of Injury	28c. Injun Wori M 1 🗆	∤at k? Yes 2 □ No	28d. Describe how	injury occurred			
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á	spitel or A ours after nerel Dire filled in b	Serti	4 Homicide determined building, et	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,				
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5			Mue m.D.			D5441	3	3/6/200	8		
			30. Name and address of person who completed cause of d		,		0100-				
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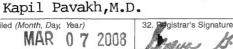
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	Dbi.i		1. Decedent's Name (First, Middle, L	ast)					2. Date of Deatl		Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, g		nber)		4b. City, Town, o	r Location of Death		4c. County of		
		42	Homewood Retirem	ent Cent	er		Williams	-		Washing		
100	Funeral		Social Security Number 6.	Sex 1 □ M 2 🛣 F		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Countr	ce (State or Foreign y)
92.	Director		216-38-0820	1 LIM ZLALF	67	Yrs.			Aug. 31	,1940 M	Mary1	and
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	he M 28a-f outfie	ect	Maryland Washing 10e. Street and Number	ton Coun	ty   Ha	agerstow			144	ng. Citizen of Wh	- A Countr	
	a or be n	ä					10f. Zip Code			U.S.A.	at Country	y :
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	item item ner	5	1 Never Married 2 Married	Armed Fo	rces?	10.0.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black,	White, et	c.
36	ırs af II", or xami	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e		1 ☐ Yes 2 ሺ No	Specify:		Specify:	Whit	e
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed by	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busi	iness/Indu	stry
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an	2 should and Men Is marke		19a. latormant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Number or Rui	ral Route Number,	City or Town, S	tate, Zip C	Code)
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ore	ω <del>+</del> ≥ 0		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3		20	<li>b. Place of Disposition of Disposition of Disposition (Property) of the Disposition of Disposition (Property) of the Disposition (Property) of D</li>	osition (Name of matory or other plac	ce) 3-14	Pate 12	20c. Location - C	ity or Tow	n, State
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Baltimore,	permit. Page: Department o Important: If any injury or once.		21. Signature of Funeral Service Lic	21742	A <sub>B</sub> Fier	y Fu	neral					
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that c y one cause on e	aused the d ach lee.	eath. Do	ter the mode wir	ng, such as cardiac	or respirato	est,	Í	Approximate nterval Between
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	Sit of	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a cons	sequence of):						
	ecute and -tran	Examiner	that initiated events resulting in death) Last	c	or as a con-	sequence of):						
68760,	tificate be executed ig physician and as the burial-transit	三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田		540 10 (	0, 40 4 0011	ooquonoo oij.						
387	icate phys s the	edical		d			·			·		
			IF FEMALE:	23c. If yes, out	come pf pre	egnancy				23d. Date	of deliver	v.
Box	eath cert attendin for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2□F ant at time	etal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	у		Mont		y Day Year
P.O.	the d y the ched	ysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unkno								
	The law requires that the death cer the has been signed by the attendin bage 2 should be detached for use		Part II. Other significant conditions	contributing to de	ath but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contrib	oute to the	cause of death?
Records,	juires n sigr	d by							1 □ Ye	es 2∐No 3	3□ Proba	bly 4 Unknown
00	w requir been si should	lete							24a. Was ar	24b. W	ere autop	sy findings available
Re	he lav e has ige 2 :	Completed					· · · · ·		autops perforn	y pri ned? de	ior to come eath?	pletion of cause of
Vital	in: T ificate or, pa		25. Was case referred to medical					OC Place of Dead	1  Yes 2 th (Check only one	<u>C</u>	∐Yes 2	2 ☐ No
<u>=</u>	Physician: r this certific ral director,	o Be	examiner?	Hospital:	npatient 2	2 ☐ ER/Outpatie	nt 3 DOA Oth	or: • C	ome 5□Reside	,	(Specify)	
ō	Phy er this eral d	2	27. Manner of Death	28a. Date	of Injury	28b. Time o			28d. Describe ho	~		
lon	th. :: Afte	흝	1 Natural 5 ☐ Pending 2 Accident investigati		h, Day Yeai	r) Injury		rk? Yes 2 □ No				
Division	Atter	iji Ligi	3 ☐ Suicide 6 ☐ Could not determine	28e. Place	of injury - A	t home, farm, st	reet, factory, office		28f. Location (St.	reet and Number	r or Rural	Route Number,
Ö	al or	Certification:	4 [ ] Tomicide	bulluli	ng, etc. (Sp	ecny)			City or Town	i, State)		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying I	hysician: To the	best of my	knowledge, deal	h occurred at the ti	me, date and place, opinion, death occur	, and due to the ca	ause(s) and man	ner as sta	ated.
	the Hi in 24 the Fi plete	Medical	one)	and manr	ner stated.							
	To t To t	Σ	29b. Signal de by Title of certifier	1/ .	X	,	29c. Livens	se number	25	9d. Date signed	Month, D	Pay, Year)
			MANY	METXC	th I	recta	<u> </u>	11/06 /		5/11/	2000	
0 4	11-7		30. Name and address of person wh	completed caus	e of death (	Item 23a) (Type,	PTY A.	Char		Mile	15	ń.
3	H-3		STEPHENE ME	iova,	WY)	13454	PATTLE	[ HOOMS	teen,	MKD 2	1/4	2
	Sta		31. Date filed (Month, Day, Year)	32./P	gistrar's Si	gnature	med		/			
	Registr	ar	MAR 1 2 2	100 B	1	N 19	-					

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

31. Date filed (Month, Day, Year) MAR 07

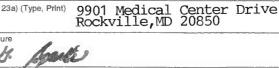
29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MO 64814



29c. License number

D0064814

29d. Date signed (Month, Day, Year)

March 5, 2008

State

Registrar

			1 - For State Registrar	State of M	aryland		artmen tificat			nd Me		giene 008	09312
	Physici /Medi		Decedent's Name (First, Middle, Last     Peter John Dante							М	2. Date of Dea Month [arch 9	Day Yea 2008	11:00 PM
	Examir	er	4a. Facility Name (If not institution, give				4b. City, Hage:	rsto	Location of WN If Under 2				on County
<i>P</i> .	Funeral Director		5. Social Security Number 6. Se 076-07-9974	WM 2006	ie (In yrs. Ia 6	Yrs.	Months	Days	Hours	Min. J	3. Date of Birth (Month, Day (an 16,	(Year)	irthplace (State or Foreign Country) York
	Maryland a-f ehow	tor	10a. State 10b. County Maryland Washingto	n County		Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 XNo
	th with the 23a or 28	al Directo	10e. Street and Number 13802 Weber Way				10f. Zip	Code 742				10g. Citizen of What (	Country?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If filem 27 is marked other than "naturel; or items 23a or 28a-f ehow if if fem 27 is marked other than "naturel; or other traumatic event, the Maclical Examinal must be inclined at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 TYPes 2 If Yes, Give Year or Dates:		l l	Vas Deced Yes, spec		spanic Origin, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)	14. Race - An Black, Wh Specify: Wh	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Edu (Specify only highest grad			life. L	kind of wo DO NOT us	rk done d se retired,	uring most	of working	7	16b. Kind of Busines	s/Industry
land 2	should be filed and Mental Hygie marked other i umatic event, II	To Be Co	8 17. Father's Name (First, Middle, Last) James Dante			Genera	11 10	rema	18. Mother		First, Middle,	Maiden Surname)	Manufacture_
Mary	. I and 2 should be Health and Mental fem 27 is marked of other traumatic ev		19a. Informant's Name/Relationship (T) Martha Dante-wife	rpe, Print)					nd Number	or Rural i		r, City or Town, State	Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 eny injury or other once.		20a. Method of Disposition  1 🔀 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	lemoval from State	20b. Pla	ice of Dispo metery, crem Patric	sition (Nan	ne of ther place	e)	Da 3-14-	te	20c Location City of Islip, New	
Balt	Depart Depart Import eny inj		21. Signature of Funeral Service Licens  Karthy Za	Haron	•	1.	OOT E	aste.	LII DT	vu. N	огип п	Fiery Fur agerstown,	eral Home MD 21742
	Physician /Medical Examiner		23a. Part1. Enter the disease or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	ne. SA	rie		,	e, such as c	ardiac or i	respiratory ari	rest,	Approximate Interval Between Onset and Death
	icale be executed physician and s the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or sa									
.O. Box 68	ine law fequires that the death certainas ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	leath 3 🗌	Ectopic pro					23d. Date of d Month	elivery Day Year
rds, P.	w requires that been signed t should be det	ρχ	Part II. Other significant conditions con	ntributing to death b	ut not result	ling in the ur	iderlying ca	ause give	n in Part I.				to the cause of death?  Probably 4 Unknown
al Reco	cate has be page 2 sh	Completed									24a. Was a autop: perfor	sy prior to	
Division of Vital Records,	to the trospite of attending projection: the within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner? 1	lospital: 1  Inpatie 28a. Date of Inju (Month, Da	ry 2	P/Outpatient 28b. Time of Injury		8c. Injury Work	r: 4□ Nurs	sing Home		ence 6 Other (Sp ow injury occurred	ecify)
Divis	el or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At hom c. (Specify)	ne, farm, stre	eet, factory	, office		28	f. Location (S City or Tow	treet and Number or i n, State)	Rural Route Number,
	within 24 hours and the Funerel I completely filled	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ner: On the best of and manner sta	examination	led e. death on and/or inv	occurred estigation,	at the tim in my op	e date and inion, death	lace an	d due to the clat the time, d	ausals) and munnar late and place, and di	e to the cause(s)
)	With To 1	2	29b. Signature and title of certifier	20/	>		0	License	5599	i 4		3///	nth, Day, Year)
31	1-4+1		30. Name an address of person who co	Au 11115	one,	DICA	Print)	HA	ser.	2	SITTE	40 21;	740
	Sta Registr	re	31. Date filed (Moolth, Day, Year)  MAR 1 2 20		ar's Signatu	To A		•					

			State of Maryland / Department of He legistra/MEND#10e, fperFH 3/13/08, BWI, MCO Certificate of D	ealth and M Death		giene leg. No 2001	3 093	3   3
7	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month			
	/Media	cal	Rose Doying  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or L		March	03, Yea 03, 200		рМ
	Examir	ier				Montgo		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	1 9. E	Birthplace (State o	r Foreign
di e	Director		216-40-5069 1 M 2 M F 95 Yrs. Months Days	Hours Min.	Jan. 31		Ohio	
	and ww		Usual Residence of Decedent  10a. State Mary Land  10b. County Sandy Spring				10d. Inside Cit	ty Limits
	Maryl -f sho ied a	호	Maryland None 10b. County together Sandy Spring Washington				1 ☑ Yes	2 🗌 No
	h the	Director	10e. Street and Number 1635. Hickory Knoll Road 10f. Zip Code		1	10g. Citizen of What	Country?	
	ith wit		1224 Decatur Street, N.W. 20860			United S	tates	
21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, specify Cuban, If Yes 2 ☒ No If Yes, Give Year or Dates:	panic Origin? (Spe I, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:	nerican Indian, hite, etc.	
5-0	hin 72 ho e. an "natul Medical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired)	tion uring most of worki	ing [	16b. Kind of Busines	-	
121	는 ci 도 M	Id III	Elementary/Secondary (0-12) College (1-4or 5+)			National I		of
d 2	filed Hygint, t		3 Research Ass		(First, Middle,	Maiden Surname)	11th	
an		To Be	Carl Schneider	Charlot	te Unk	nown		
Maryland	sh and sund sund sund sund sund sund sund su		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and	nd Number or Rura	al Route Numbe	r, City or Town, State	e, Zip Code)	
Σ,	s 1 and 2 if Health item 27 I		Virginia Parker / Daughter 1224 Decatur St					
Baltimore,	f i		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cernetery, crematory or other place)	)   [	Date	20c. Location - City	or Town, State	
Iţim	permit. Page Department ( Important: If any injury or once,		4 □ Donation 5 □ Other (Specify) Fort Lincoln Cremat  21. Signature of,Funeral Service Licensee 22. Name and Address			Brentwoo	d, MD	
Ba	permit. Pag Department Important: i any injury o once.		21. Signature of Funeral Service Licensee 22. Name and Address 1040 Rockvi		Simple '		0000	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, of heart failure. List only one cause on each line.				Approximate	е
Va.	Physician /Medical		Immediate Cane (Final disease or condition resulting in death)  Sequentially list conditions,  Due to (or as a consequence of):  Due to (or as a consequence of):				Interval Bette Onset and D Minul	Neen Death
40	Examiner		ty perten	sion			year	× (
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				1	
	cate be executed ohysician and the burial-transit	Examiner	that initiated events  C.					
8760,	be ex ician a burial		Due to (or as a consequence of):					
687	ficate physi s the	dica	d			<u> </u>		
P.O. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 V No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown			23d. Date of Month		Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	ı in Part I.	23e. Did to	bacco use contribute es 2□ No 3□		leath? Jnknown
Division or Vital Records,	The law re ate has bee page 2 sho	Completed			24a. Was a autop: perfor	sy prior		available ause of
ital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death		/	63 20110	
<u> </u>	nys dir	70 E	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:	4LJ Nursing Ho	me 5 🗆 Resid	ence 6 □Other (S	pecify)	
ou c	ding P	ion:	27. Manner of eath 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury a Work?		28d. Describe h	ow injury occurred		
isi	I or Attending after death. Director; Aftel in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office	es 2 No	28f Location /S	treet and Number or	Rural Route Num	nher
Ω	al or A after I Dire	erti	4 Homicide determined determined building, etc. (Specify)		City or Tow			,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physiclan: To the best of my knowledge, death occurred at the time 2 Medical Examiner: On the basis of examination and/or investigation, in my opinand manner stated.	e, date and place, inion, death occurr	and due to the ored at the time, or	cause(s) and manner date and place, and o	as stated. due to the cause(s	;)
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License r	- 1	2	29d. Date signed (Mo		
,	b		1.6. 33	624		3-3.	-08	
1	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
			John C. Downs, M.D. 7505 Osler Drive #302, To	owson, M	21204			
	Sta Registr		MAR 1 0 2008					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008	09314
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Roswitha Theresa		ınlap - For State	St	ate d	of Marylar	nd / E	epartm <i>Certific</i>		Health and Death	d Ment	al Hyg		- N-	20	<i>i</i> U	0 0 0 0 1
Physician		egistrar I. Decedent's Name	e (First, Midd	le,Last)							2	. Date of Dea		Veet	3	. Time of Death
Medical Examine	r	Roswi	tha	Τ.		Du	nlap					Month March 12,				1147 hrs
East .	-	a. Facility Name (i		n, give	street and num	nber)		41	D. City, Town, or Rockville	Location of	f Death			. County of De Montgomer		
	4	9 Elmwood				* A (I	look bis	th do\	If Under 1 Year	Lift Inde	r 24 Hrs	8 Date of Ri		•	•	place (State or Foreign
Funeral Director		5. Social Security N 544-64-31		6. Sex	M 2XF		n yrs. last bir 60	Yrs.	Months Days	-	_	Feb.			Cour	ermany
any	-	Jsual Residence of 10a. State	Decedent 10b. County			10	c. City, Towr	or Location	on						1	10d. Inside City Limits
		MD		taar	mery			Roc	kville							1 Yes 2 X No
uylanı Sa-f sh	ᆰ	10e. Street and Nu		Lgoi	пету	!		1100	10f. Zip Code		-	1	10g. Cit	izen of What (	Count	y?
h the Maryland 3a or 28a-f sh totified at one		9 Elmwoo	od Cou	rt		_				20850				rmany		an Indian, Black,
i, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygien. traumatic event, the Medical Examiner must be notified at once.	unera	11. Marital Status  1 Never Marri	ed 2 N	larried	12. Was Dece Armed For 1 Yes				Decedent of His s, specify Cubar				J-	White, et	tc.	
affer of a	<u> </u>	3 Widowed	4 X Di	vorced	If Yes, Give Year or Dates:			L	Yes 2 X No					Specify: V		
hours		15. Decedent's Ed							's Usual Occupat ost of working life					Kind of Busine		
36 in 72 l in 72 l lical F	ompiered	Elementary/Seco	ondary (0-12)		College (1-	4 or 5+)		Paca	ptionis	+			N.	ational Orches		ymphony
d with	틹	12 17. Father's Name	(First, Middle	, Last)				Rece	PETONIS		's Name (	First, Middle,	Maider		JUL	a
21215-0036 uld be filed within 77 Mental Hygione. marked other than e event, the Medical	g	Heinric	ch Ham	ber	ger							eidel				
21.	9	19a. Informant's Na	ame/Relation	ship (T	ype, Print )				Address (Stree							Zip Code)
MD id 2 should and and 27 is aumati	L	Christo		. D	unlap/S	on			akview I			n Carl Date	OS,	CA 940	J/U	own. State
Baltimore, oernit. Pages I ar Department of Hee Important: If ite	1	20a. Method of Dis 1 Burial 2		n 3 [	Removal fro	m State	crema	atory or oth	er place)	inetery,	l	ch 18			•	
lime Page Iment tant:	1	4 Donation 5					Metro	Crem	atory ame and Addres	of Facility	200		Al	exandr	ıa,	, VA
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If tiem 27; smarked oth injury or other traumatic event, the 1		21. Signature of FL						De	Vol Fun	eral	Home	, 10 E	ast 087	Deer I	Par	k Drive,
Physician	┪	23a. Part I. Enter th	ne disease, o	r comp	lications that ca	used the	e death. Do	not enter th	ne mode of dying	, such as c	ardiac or	respiratory ar	rrest, sh	ock, or heart		Approximate Interval Between Onset and
Medical		failure. List or Immediate Cause	•			vline	and Al	lcoho1	Intoxicat	ion						Death
aminer	-	or condition resulti			Due to (or as a											
	۱.	Sequentially list co		b.	Due to (or as a	consequ	uence of):				_					
-		cause. Enter Und	erlying Cause	С.												
ansit de	Examin	events resulting in		d.	Due to (or as a	conseq	uence of):									
50, te be executed ysician and burial - transit	edical	X UNPENDED	)		AMENDED	23a,2	27,28a-f	per N	Æ g877 3/	31/08	amh					
760, cate be	ĕŀ	IF FEMALE:		***	23c. If yes, o	outcome	of pregnance					-	2	3d. Date of de		Vaar
6876( certificate nding phy.	an	23b. Was decedent past 12 month	s?	tne	1 Live b		ne of death		tal death 3	Ectopi	c pregnar	ncy		Month	D	ay Year
Box e death c the atter	Physician/M	1 Yes 2 🗸	No 9 U	nknown				3 Ot	her (Specify)							
O # 7 # 1		Part II. Other sign	ificant cond	itions	contributing to	death t	out not result	ing in the u	inderlying cause	given in Pa	art I.				_	he cause of death?
s, P.	og pá															ably 4 V Unknown
w request should													s an opsy formed	pric		topsy findings available ompletion of cause of
Reco	Completed											1 V Yes			<b>∕</b> Ye	s 2 No
of Vital Records,  ig Physician: The law requir  Mer this certificate has been s  meral director, page 2 should	Be	25. Was case refe examiner?	rred to medic	_	Hospital:					e of Death			75.	dence 6	045	Carra
Physic rathis	2	1 Yes 27. Manner of Dea	2 No	<u>_</u>		of Injury		Outpatient		ury at Worl	`	g Home 5		njury occurred		. Scene
n o n o o o o o o o o o o o o o o o o o	<u></u>	1 Natural		nding	28a. Date (Month		r)		1	Yes 2 X	71 No.	Unknown				
Division tal or Attendid as after death.	<u>[</u> 2	2 Accident	6 X Co	estigati	20a Dias			ound 11 , farm, stre	et, factory, office	building, e	40	not Leastion	(Stree	and Number	or Ru	ral Route Number, City
Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certification in the funeral director.	Certification:	3 Suicide 4 Homicide		ermine		House	2					Rockvil	Le, I	9 Elmwox	od (	burt
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier	Certifying Medical Ex	Physic amine	n:On the basis	of exami	knowledge, onation and/o	death occur or investiga	rred at the time, o	date and pl on, death o	lace, and ccurred a	due to the ca t the time, da	use(s) te and p	and manner a place, and due	s state e to the	ed. e cause(s)
To with To con	Med	29b. Signature and	-		and manner s	tated.	<del></del>			se number					_	nth, Day, Year)
6 pen		Jam	THE	WH	Kull n	21			0.0	.M.E.			М	arch 13, 20	800	
		30. Name and add	-/		completed cause	se of dea	ath (Item 23a al Examir	ner 11	1 Penn Stre	et, Baltir	nore, M	1D 21201				
Sta	ite	31. Date filed (Mo			2. Re		Signature	Ann. P	En							
Registr	ar	MA	R18	2008	Along	MI	10. 1	97000				·				
DHMH 17 Rev 1/200	01						Ċ	RIGINA	<b>NL</b>							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 ear **Physician** ELLA ESTEP MAR. J. 1, 2:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Mar. 18, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗙 F 83 Yrs. Director 214-28-9017 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ? Te marked other then "natural, or items 23a or 28e-1 show treumatic event, the Medical Examinar must be notified at Yes 2 □ No Director MD Montgomery Sandy Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19 Branchwood Court 20860 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturai; or iten eny injury or other treumetic event, the Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Specify: Black 2 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery Co. Elementary/Secondary (0-12) College (1-4or 5+) 10th Bldg. Service Worker Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James T. Hill Ella Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl M. Estep (Son) 313⅓ Frederick Ave.,Rockville,MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem 3/8/08 Silver Spring, MD \* 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ungral Service License 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner burial-transit Due to (or as a consequence of): Box 68760 90 ician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No P 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred : After Certification: 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified De062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reckville, MD 20850 SAYED EISAYYAU 31. Date filed (Month, Day, Year) State 7 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Month March 6, Frances Anita Frazier 12:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care-Silver Spring Silver Spring Montgomery 8. Date of Birth (Month, Day, Year)
Oct. 13, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Vrc 579-52-5320 68 1939 Washington, DC **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 TYes XX No Director Montgomery Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Musgrove Road 20904 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 21⁄ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No speciWhite þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Is marked o Charles William Yates Mary Katherine Higgs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl L. Lowe/Daughter 3 Angela Court, North Caldwell, NJ 07006 item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or otl March 10, tx Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2008 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the a 9□Unknown 9 Unknown ģ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Chronic Lymphocytic Leukemia, Dysphagia Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? (es 2 No death? certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Hospital or Attending 1X Natural ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, Gaithersburg, MD 20878 Raman Tuli, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 07

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

32 Registrar's Signature

2008

4b. City. Town, or Location of Death

2. Date of Death March 6,

Day 2008 Year

4c. County of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

8:15 PM

Physician
/Medical
Examiner

1. Decedent's Name (First Middle Last)

Pauline K. Franks

4a. Facility Name (If not institution, give street and number) Montgomery Brooke Grove Rehab. & Nursing Sandy Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Aug. 9, 19. 5. Social Security Number 9. Birthplace (State or Foreign Country) Ireland 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 💥 □ F Director 279-46-8287 87 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 USA 9321 Gue Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black. White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 9 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malcolm Edward Moir Beatrice Muriel Oldfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9321 Gue Road Damascus, MD 20872 Roger Franks/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 03/11/08 Beltsville, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest, iratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 12 hours disease or condition resulting in death) a Pulmonary Insufficiency omt /Medical Due to (or as a consequence of): Examiner 7 days b. Pleural Effusion Sequentially list conditions if any, leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequ Examine 1 month Malnutrition and use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Ø Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 📉 No 3 ☐ Ectopic pregnancy 5 ☐ Other\*(specify) \_\_\_ 4□Pregnant at time of death 9□Unknown Month Day Year signed by the at d be detached fo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Fractured Right Hip 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 02/07/08 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Natural 7:00 AM 1 ☐ Yes 2 [X]No fall from standing death. 2 🙀 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) at home  $^{28i.}$  Location (Street and Number or Rural Route Number, City or Town, State)  $9\,32\,1\,$  Gue Road Damascus, MDdetermined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35965 March 7, 2008 30. Name and address of person who completed cause of death (them 23a) (Type, Print) 18111 Prince Philip Dr. Suite 300 Olney, MD 20832 Harding, M.D. 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature MAR 1 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MARCH 17 2008 4:17 a JUDY G. FARROW /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 811 Pond Neck Rd. Earleville Cecil If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗗 F 55 Yrs Virginia 215-58-4298 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Directo MD Cecil **Earleville** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 811 Pond Neck Rd. 21919 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married ò Specify: White 1 ☐ Yes 2 XNo ģ 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygienist Dentistry 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be filt Department of Heelth and Mental Hy Important: If Item 27 is marked oth any ligury or other treumatic event appe. Millburn Janice Gilliam Lois Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21919 David B. Farrow 811 Pond Neck Rd. P.O. Box 46 Earleville MD (husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Stephen's Cem. 3/21/08 Earleville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Galena Funera 118 West Cros 21. Signature of Funeral Service Dicenses Galena Funeral Home of Stephen 118 West Cross St. Galena, MD, and or or head lailure. List only one cause on each line. L Schaech 21635 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 ☐ Yes : After this certifice a tuneral director, i Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3□ DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Yes 2 No death. investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date liled (Month, Day, Year)

32. Registrar's Signature

Il West

4 2008 As a serial of the seri

address of person who completed cause of death (Item 231) (Type, Print)

ORIGINAL

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIPM/29d, per HYS., 08/7, 3/21/08, WS. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** CARLA RUTH GRITZMACHER MAR.10,2008 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7673 SPRING OAK DRIVE LA PLATA CHARLES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🙀 F 61 Director 279-44-5900 OHIÓ 7-11-1946 Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2√ No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 7673 SPRING OAK DRIVE 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 CHARLES COUNTY Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If them 27 is marked other the any injury or other traumatic event. SCHOOL TEACHER BOARD OF EDUC. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARL FRANKLIN WAINWRIGHT DOLORES EVELYN BAHNSEN ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH C. GRITZMACHER-SPOUSE 7673 SPRING OAK DR. LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VETERANS CEM. 3-18-08 CHELTENHAM, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 10 licha LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that collised the death. Do not noter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eight line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** month disease or condition resulting in death) ACUTE LEUKEMIA /Medical Due to (or as a consequence of): Examiner METESTATIC PAROTID TUMOR Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery that the death 3 Ectopic pregnancy in the past 12 months Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown g □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1□ Yes 2☑No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Profile 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending Injury 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/10/2008 203 30. Name and address of person who completed cause of centh (Item 23a) (Type, Print) 15 HARVEY KATZEN MD 8926 WOODYARD RD. CLINTON, MD. 32 Registrar's Signature State

Registrar

the state of the state of

			For State Registrar	State of Maryland			of Health a of Death			iene (eg. No.	900	09320
			Decedent's Name (First, Middle, Last)					2	. Date of Deat		Year	3. Time of Death
	Physici		Shirley M. Gord	lon				Ma	arch 4	1, Day 2	008	22:30 M
	/Medic Examir		4a. Facility Name (If not institution, give str			4b. City, To	own, or Location	of Death		4c. Co	ounty of Death	
	= Admin		Washington Adver	ntist Hospit	tal	Takon	na Park			Mon	tgomer	У
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la			Year If Under Days Hours	24 Hrs. 8	Date of Birth	Year)	9. Birthpl	lece (State or Foreign
	Director		577-56-6829 <sup>1□1</sup>	<sup>M 2</sup> XF 64	Yrs.	Months	Jays Hours		une 23	3,19	43Wash	ington, DC
	D.		Usual Residence of Decedent									0.4.1
	rylar show		10a. State 10b. County		Town or Lo							Od. Inside City Limits
	Ba-1 s	cto	DC	7	Nashi	ngtor						1√ Yes 2 No
	death with the Maryland ms 23a or 28a-1 show prived be notified at	Director	10e. Street and Number			10f. Zip C	ode		1		n of What Coun	try?
	23a	a	1105 Eaton Road,	S.E.			20020				SA	
	sams ams	Funeral	Tr. Islaniai Giales	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	13.	Was Deceder	nt of Hispanic Ori / Cuban, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	14	. Race - America Black, White, e	
õ	or It	y F.	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 □ Yes 2	Ö No Specify:	:		S	pecify: Bla	ck
9500-c	within 72 hours after ene. than "natural", or Ita	d by	3 Widowed 4 Divorced	Year or Dates:	10. 0	4	0					
'n	nat nat	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual I kind of work DO NOT use	done during mos	st of working		IOD. KING	of Business/Ind	lustry
7	than than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)	<i></i> 0. 1	Nurse	,			DC	Villia	ae
Z	be filed within 72 hours after death with the Marylan ital Hygliene. diother than "natural", or Itams 23a or 28a-1 show event. The Medical Exteriminal har collided at		17. Father's Name (First, Middle, Last)			Nulse		er's Name (	First, Middle, I			. 5 -
yland		Be	Unknown				Lor	etta	Gordo	าท		
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٥	leath certific attending p I for use as	Me	IF FEMALE:							10		
X P P	th ce	an/	23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregnant</li> <li>1 ☐ Live birth 2 ☐ Fetal</li> </ul>	death 3	Ectopic pres				23	<li>d. Date of delive Month</li>	ery Day Year
5	e des he al	SICI	1 ☐ Yes 2 📉 No	4☐Pregnant at time of del 9☐ Unknown	ath 5	Other (spec	cify)		1 10			,
٦ ک	at the	Physician/Me	9 Unknown	76 . 15	M11-46-	- db !			220 Did to	hagge use	oontribute to th	ne cause of death?
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r	sicien: The law certificate has t irector, page 2 s	TO.							1 Yes	med? 2 <b>X</b> No	death? 1 ☐ Yes	2 No
VITAI	len: rtifica stor. I	Be	25. Was case referred to medical				26. Place	e of Death	(Check only or	re)		
	> 0 0	To	examiner? 1 □ Yes 2 🛣 No	ospital: 1 X Inpatient 2 □ E	R/Outpatier	nt 3 DOA	Other: 4 N	ursing Hom	e 5 🗆 Resid	ence 6[	Other (Specifi	y)
101			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	c. Injury at Work?	28	d. Describe h	ow injury	occurred	
0	Attending For death.	atlo	1 Natural 5 Pending 2 Accident investigation		,,	М	1 Yes 2	]No				
DIVISION	A - o o	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, sti	reet, factory,	office	28	of. Location (S City or Town	treet and i	Number or Rura	al Route Number,
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	To the Hospitel  within 24 hours a  To the Funeral Completely filled		(Check only 2 Medical Examine	cian: To the best of my knower: On the basis of examinati								
	thin 2 the mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c.	License number		2	9d. Date	signed (Month,	Day, Year)
	F 3 F 8		Chandrase	Illian that	hana	A	D528	250			5 - 20	
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			30. Name and address of person who con				Makoma	Dawl	MD	209	112	
			Dr. Korapati 7	800 Carroll 32 Registrar's Signate	AVel	iue,	Takullid	ralk	ווים ו	203	, 1 4	
	Sta Regist	ate rar	31. Date filed (Month, Day Year) 2008	Marie Si	1 Ale	out						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0932 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month O3 ERWEST R. GALM 320 PM 06 08 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURA 2 Rehas ANCHORNEE NURSING If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1♥M 2□F 007-32-1414 75 2-6-1933 Maine Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 E. Chestnut Street 21875 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1953 1 ☐ Yes 2 No Specify: Specify. 3 X Widowed 4 ☐ Divorced 1955 Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Painter Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Galen Bertha Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Whaley - Personal Rep. 502 E. Chestnut Street, Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-11-2008 Hebron, Maryland Springhill Memory Gds. 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

attending physicien and for use es the burial-trans

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**Physician** 

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**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other treumatic event, the Medical Exercipat must be reutified at Anne.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

29a. Certifier

Physician/Medical ģ Completed Be 2 ٩ Medical Certification:

To the Hospital or Attending Physicien: The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

23e. Did tobac	co use con	tribute to the cau	ise of death?
1 🗆 Yes	2 🗌 No	3 Probably	4 Unknow

Death (C

1 🗆 Yes	2 🗌 No	3 Probably	4 Unknown
da Wasan	24h	Were autonsy fir	ndings available

5. Was case referred to medical examiner?				26. Place_of
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3□ DOA	Other: Nursin
7. Manner of Death	28a. Date of Injury			Injury at

	psy prmed?		prior to codeath?	ompletion of cause	of
1 Yes		_	1 LI Yes	219 No	
check only	nnel				

Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

Oalet.	Nursing H	lome	5 Residence	6 ☐ Other (Specify)
Injury at Work?		28d.	Describe how inju	ury occurred
1 Yes	2 No			

12

determined	building, etc. (Specify)	City or Town, State)
1☑ Certifying Physi	cian: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.
2 Medical Examine	of: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	urred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier M

29c. License number D63433 29d. Date signed (Month, Day, Year) 030

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06 MUFORD ST, 8MTZ 504B, MD 218041 31. Date filed (Month, Day, Year)

State Registrar

MAR + 0 2008



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 0028 M Richard Thomas 4 200% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Medical Center Baltimore University Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year 6/28/1940 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Min Country) Maryland 1**⊠** M 2□ F 67 220-38-3582 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Wicomico Maryland Hebron 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7399 Cherrywalk Road 21830 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ ※ S □ No If Yes, Give Year or Dates AirForce Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Air Force career military other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milford P. Goslee Edna Croswell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rose Goslee/wife 7399 Cherrywalk Rd., Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or or 1 XBurial 2 ☐ Cremation 3 Removal from State 3/8/08 Hebron, MD 5 Other (Specify) Gardens Euneral Service Name and Address of Facility Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 28a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Acute Myelogenous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an has autopsy 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Joseph Haas

31. Date filed (Month, Day, Year) MAR 0 7 2008

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grune

DHMH 17 Rev 1/2001

29c. License number

P-21195

Baltimore MD 2120

29d. Date signed (Month, Day, Year)

3/4/08

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3 Registrar's Signature

Registrar DHMH 17 Rev 1/2001 **OCME 2006** 

State

111 Penn Street, Baltimore, MD 21201

29c. License number

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29b. Signature and title of certifier

Ling Li, MD 31. Date filed (Month) 62

Day, Year)

MAR 18

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

2008

29d. Date signed (Month, Day, Year)

March 15, 2008

		State of Maryland / Depa		•	•	
		A 1200	tificate of Death		2008	09326
Planei e	₹*	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
Physici /Medi		Robert Berkley Hammond			14, 2008	11:06 Рм
Examir	ier	4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice Care	4b. City, Town, or Location of Death  TOWSON		4c. County of Death Baltimo	
Funeral	*	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birth	nplace (State or Foreign
Director		215-24-1470	Months Days Hours Min.	April 16	, 1929 Ma	ryland
arylanc show	'n	10a. State 10b. County 10c. City, Town or Loc MD Baltimore Parkto				10d. Inside City Limits 1 ☐ Yes 2 No
the M 28a-f notifie	Funeral Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	
th with 23a or ist be	al Di	440 Dairy Road	21120		U.S.A.	,
r deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Warmed Forces? 15. Marital Status	L /as Decedent of Hispanic Origin? (Spo Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married   1 May Yes 2 No	□Yes 2X No Specify:	,		hite
72 ho 72 ho 'natur dical I	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of work O NOT use retired)	ina 16	6b. Kind of Business/I	ndustry
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buld be Menta arked atic ev	To B	Harry Hammond	Berkle	y Peeli	ng	
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permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility J. 3	. Harter		
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ss that	y Pt	Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
require een sij				1 ☐ Yes	2 No 3 Pro	bably 4 □Unknown
The law ate has b page 2 sl	Completed			24a. Was an autopsy performe 1□ Yes 2	prior to c death?	topsy findings available ompletion of cause of
ician: certific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death	Check only one)		-11
Phys er this eral dir	 12	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residence	ce 6 Other (Spec	ity) Hospice
ath. r: Afte	atior	1 ☑Natural 5 □ Pending (Month, Ďay Year) Injury 2 □ Accident investigation	28c. Injury at Work?  M 1 □ Yes 2 □ No		injury coccinco	
al or Atte s after de al Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my knowledge, death 2☐ Medical Examiner: On the basis of examination and/or investant manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
To t withi To t	Σ	29b. Signature and title of certifier  Manthy Riley i	29c. License number	29d	I. Date signed (Month NACL 1	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	Ces St. Balto	md 2	1204	
Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	A B		/	
Registra		MAR 2. 4 2008				

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State

Registrar

31. Date filed (Month, Day, Year)

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3 Registrar's Signature

			Please 7	Type or Print in B						•	
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Į.	6 -		Registrar     Decedent's Name (First, Middle, Lasi	9)	Cei	inicate of i	Dealli	2. Date of D	Reg. I	No.2008	3. Time of Death
S	Physici		Elmer T. Hepb					Month	(	Day Year	4 22 M
de la	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death	March		2008 4c. County of Dea	4:20 p
	LAdiiii	e e	Holy Cross Hospi			Silver S				Mont	gomery
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Bir	thplace (State or Foreigr
	Director		577-26-1197	⊋M 2□F 83	Yrs.	Months Days	Hours Will.	Aug. 3			hington, DC
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Lo	cation					10d. Inside City Limits
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	the 128a-notifi	Director	10e. Street and Number	3		10f. Zip Code			10g.	Citizen of What.C	ountry?
	be filed within 72 hours after death with the Maryland ntal Hyglene.		3014 Blueford Ro	oad			895			USA	
	ms 2; mus	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or N	lo-	14. Race - Amo	
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1. <b>KX</b> es 2 ☐ No If Yes, Give		if Yes, specify Cuba 1 ☐ Yes 2 🛣 🎞 o	an, Mexican, Puert Specify:	o Rican, etc.)		Black, Whi	te, etc. White
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215-0036	72 h "natu dical	etec	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b.	. Kind of Business	/Industry
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ä	ould be i Mental I arked or atic eve	9 B	Charles Alexander	Hepburn			Ethel R.	, ,		,	
2	should Ind Men marke	은	19a. Informant's Name/Relationship (7)	/pe. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Num	ber, Cit	ty or Town, State,	Zip Code)
Baitimore, Maryland 21	es 1 and 2 should be of Health and Mental f Item 27 Is marked o r other traumatic eve		John Hepburn/ Son		13220	Trumpet	Place, S	Silver	Spr	ing, MD	20904
<u>o</u>	es 1 a of Hea f Item r othe		20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place	e) Man	Date rch 11,	20c.	Location - City or	Town, State
Ē	Pages nent of unt: If Its ury or o		15 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	removal from State		n Memoria	,	2008	Roo	ckville,	Maryland
a	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Licens	see	22	2. Name and Address	ss of Facility	- E	_ 7 _ 7		
n	99 = 50		1 & ams &	rlock	5	00 Unive	rsity Bly	vd W, S	ilve	er Spring	, MD 20901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death ne cause on each line.	Do not ent	er the mode of dyin	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Non-Small (	Cell I	ung Cance	er				Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ							
	Stage	7	Sequentially list conditions,	b. Congestive Due to (or us a consequ		Failure					
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Atrial Fib		ion					
,	be executed ician and burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as a consequ		1011					
20/				d							
289	oertificate nding phys ise as the	edi		<u> </u>							
go	eath certific attending pl for use as t	N/us	Zob. was decedent pregnant	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal		Ectopic pregnancy	,			23d. Date of de	elivery
	deal	sicia	In the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of de		Other (specify)	,			Month	Day Year
r Ö	The law requires that the death the has been signed by the atter age 2 should be detached for u	Physician/Medical	9 Unknown					00. 514			
Š	res the	by	Part II. Other significant conditions co	entributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.				o the cause of death? robably 4
ecord	requ	Completed						20.00			
ě	e law has t	nple						24a. Wa	is an opsy formed	prior to	utopsy findings available completion of cause of
<u>_</u>	10 11							1□ Yes	2		
VItal	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	70.1	t 3DDOA Oth	er:				
ō	Phy r this rai d	-: To	1 Yes 2√ No  27. Manner of Death	28a. Date of Injury	:R/Outpatier 28b. Time o	I DON	4 Linursing H			e 6 ☐Other (Speniury occurred	ecify)
0	Attending I r death. ector: After by the funer	tion	1x Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ƙ? Yes 2∐No			,,	
VISION	or Atten after deat Director: in by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor	ne, farm, str	eet, factory, office					Tural Route Number,
5	tal or A s after al Direc ed in by	Certification:	4 - Homiloido	building, etc. (Specify,				City or Ti	own, St	iale)	
	To the Hospital or within 24 hours after To the Funeral Directory filled in Ecompletely		29a. Certifier Certifying Phy	sician: To the best of my know iner: On the basis of examinat	ledge, deat	n occurred at the tir	me, date and place	e, and due to th	e cause	e(s) and manner a	is stated.
	the H nin 24 the F thete	Medical	one)	and manner stated.				an eo ar me ulli			
	To Vitt	2	29b. Signature and title of certifier	1		29c. Licens	e number 2520			Date signed (Mon h 7, 200	
	17+1		MIUFOL	us						/, 200	-
	(0,,		30. Name and address of person who commaria K. D'Arbela			Print) Glen Roa	d, Silve	r Sprin	g, I	MD 20910	
								-	-		

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 0 2008



Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

	1- State Of IVIA			cate of E		vieritai riy	Reg. N	4000	09329
n	Decedent's Name (First, Middle, Last)     LILLIAN F. HAMMOND					2. Date of De Month	eath D	ay Year	3. Time of Death
al			4h	City Town or	Location of Death	March	4,	2008 c. County of Death	2:30P M
er'	4a. Facility Name (If not institution, give street and number) Fox Chase Rehab. & Nso	g.Cent	er		Spring			ontgome	
	577-36-2798 <sup>1 M 2 T</sup> 82	(In yrs. last birt		Inder 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8 / 25 /	nth ay, Yea 25	9. Birth Cou Hart	pplace (State or Foreign untry) Sville, SC
	100.01.01	10c. City, Town							10d. Inside City Limits
ctor	MD Montgomery	Silver	Spr	ing					12 Yes 2 □ No
al Dire	2015 East West Highway		10	of. Zip Code 20910			10g. C	itizen of What Cou A	untry?
Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Xwidowed 4 Divorced  12. Was Decedent Endred Armed Forces?  1 Yes, Give Year or Dates:			Decedent of His , specify Cuba es 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	D-	14. Race - Amer Black, White Specify: B13	e, etc.
eted	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's (Give kind	Usual Occupa	ition uring most of wor	king	16b.	Kind of Business/I	ndustry
mp	Elementary/Secondary (0-12) College (1-4or 5+	Co	ilife. DO N ook	OT use retired,			P	rivate :	Industry
To Be Co	17. Father's Name (First, Middle, Last) Elliot Smart				18. Mother's Nan Fannie				
-	19a. Informant's Name/Relationship (Type. Print)	19b.					_	or Town, State, Z	
	Ashby Smart/G/Nephew							le, MD	
	20a. Method of Disposition  1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		dale	(Name of y or other place Crema	tory 3,	Date / 10 / 08	RI.	Location - City or 1	, MD
	21. Signature of Funeral Service Licensee								neral Home
	23a Part Court the disease or complications that caused to	he death Do r						, wasn.	, DC 20011
	23a. Part I enter the disease, or complications that caused to shock, or heart ailure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  a. Gangrer Due to (or as a	ie			,, , , , , , , , , , , , , , , , , , , ,				Interval Between Onset and Death
7	Sequentially list conditions, if any leading to immediate		of):						
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a cause (Disease or injury that initiated events)	,	.,.						
Exa	resulting in death) Last Due to (or as a	consequence	of):						
Jical	d. HTN								
Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death		opic pregnancy er (specify)				23d. Date of deli Month	very Day Year
Phy	Part II. Other significant conditions contributing to death but	not resulting in	the underly	ying cause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
d by	Severe disorders, CKD,	CHF				1 🗆	Yes	2 No 3 Pr	obably 4XJUnknown
plete						24a. Was		24b. Were au	topsy findings available completion of cause of
HO:						peri 1□ Yes	opsy formed? 2 24	death?	_
Be	25. Was case referred to medical examiner?			Othe	26. Place of Dea	ath (Check only	one)		
2	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inpatien  27. Manner of Death ☐ 28a. Date of Injury		tpatient 3	L DOA	4 Nursing F	lome 5 Res		6 □Other (Spec	cify)
tion	1 Natural 5 Pending (Month, Day 2 Accident investigation		njury N	28c. Injun Work 1 1 □	? ∕es 2 □No	200. 50001150		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injurbuilding, etc.	ry - At home, fa (Specify)	rm, street, f	actory, office		28f. Location City or To	(Street own, Sta	and Number or Ru ate)	ural Route Number,
Medical Certification:	29a. Certifler (Check only one) 1X Certifying Physician: To the best of Medical Examiner: On the basis of and manner stat	examination an	e, death occ d/or investi	curred at the ting gation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause e, date a	(s) and manner as and place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier	117		29c. License				Date signed (Monti	
	ally,	VI )		D00	64578		Ma	rch 5,	2008
		Shady			d, Sui	te #20	8,	Rockvil	le, MD
e	31. Date filed (Month, Day, Year)  MAR 1 0 2008  33. Registra	r's Signature	1						
ır	1111111 2 0 2000	JS. A	marke	1					

Sta Registr

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		State	of Maryla		artment <i>rtificate</i>				lental Hyg	giene	08	09330
	-		1. Decedent's N	ame (First, Mide	dle, Last)							2. Date of Dea Month		V	3. Time of Death
	Physici /Medi		MARY	JANE	HAYES							March	7, 20	308	7:00 AM
	Examir	ner	4a. Facility Name	ө (If not instituti	on, give street and n	umber)		4b. City, 7	Fown, or	Location of	of Death		4c. Count	y of Death	
			13625 R			T //-		Hage			0.4 Hrs				County
т.	Funeral Director		5. Social Securit		6. Sex 1 ☐ M 2 ဩ F	7. Age (in yr.	s. last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Feb. 5,	Year)	Con	place (State or Foreign ntry) .sylvania
			Usual Residence			13						reb. J,	1933	renn	Sylvania
	show		10a, State	10b. Count		10c. 0	City, Town or Lo	ocation							10d. Inside City Limits
	Ba-f	Director			ngton Co.	Ha	gerstow	/n							1 ☐ Yes 2 ☑ No
	vith th	Dire	10e. Street and		_			10f. Zip (				1	l 0g. Citizen of		ntry?
	s 23c	Funeral	13625 R			andest Funcia	11.6	217				7 17	U.S.A		
	item item	-un	11. Marital Statu	ıs arried 2∐ Ma	Amed f	cedent Ever in forces? 2 X No	0.5.	Was Decede	fy Cuba	n, Mexicar	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	14. Ha	ce - Americk, White,	
980	urs al	by		d 4 Divorce	If Yes C	ive		1 ☐ Yes 2	No K	Specify:			Specia	<sup>y:</sup> Whit	-0
21215-0036	within 72 hours after death with the Maryland one. than "natural", or items 23a or 28a-f ehow Ita Madical Exardi ar must be notified at	Completed	(5)	15. Decede	nt's Education		16a. Dece	dent's Usual	Occupa	ation	4		16b. Kind of B		
2	ithin	npie		econdary (0-12)		(1-4or 5+)	life.	kind of work DO NOT use	e retired	uring mosi ()	t of workii		_		_
N	filed w Hygier other th		12		(4)		Home	maker							sidence
anc	nta! H	Be	17. Father's Nam									(First, Middle,		me)	
Ž	2 should be filed within 72 hours after death with the Maryla and Mantal Hygiene and Mantal Hygiene 1 show is marked other than "natural", or items 23a or 28a-f show aumatic event, tra Michical Exartal arminal be notified at	은		ng M. B	ankert ship (Type, Print)		19h Mailie	an Address	(Stroot o			Bare Ba		State 7is	Codel
<u>≅</u>	ith ar Ith ar 27 is 1 trau	i X			lett / Da	nohter						erstown,			
<u>6</u>	f Hee f Hee item	11.	20a. Method of D		ictt / Da		Place of Dispo					_	20c. Location		
Ë	Page ient o nt: ff ry or			2 ☐ Cremation n_ 5 ☐ Other (	3 □Removal from Specify)	I State				1	Com	3-12-20	വ	Vork	Pennsylvan
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic a <u>once.</u>		21. Signature of	Funeral Service	Licensee		22	2. Name and	Addres	s of Facilit					ral Home
ω	20 = 20		Du	unla	A Xu	cres	13	31 Eas	ster	n Bly		l. Hager			21742
		4	23a. Part1. Ente shock, or h	er the disease, o	r complications hat t only one cause on	caused the dea	ath. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Caus disease or cond	lition	. It	DER	IFMS	ICAN							Onset and Death
	/Medical Examiner		resulting in deat	.n)	(Pye)	(or as a conse	quence of):	- 74	_ /						7 - 20
		h.,	Sequentially list	conditions.	b	20100	1712(	11)	217	)				(	16/44>
	rted	Examiner	if any, leading to cause. Enter Un Cause (Disease	nderlying . or injury	1	(5: 45 4 65).56	7171	SIC							FARS
Ć,	execu n and ial-tra	Exal	that initiated eve resulting in death	nts h) Last	c. Due to	(or as a conse	quence of):	7/3						17	
8760,	cate be executed physicien and the burial-transit	dical			d								_		
89	ntifica ng ph	Med	IF FEMALE:												
Вох	death certifica attending ph for use as ti	an/	23b. Was deced	ent pregnant 12 months?		itcome of pregr birth 2 ☐ Fet		Ectopic pre	gnancy					te of delive	,
0	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 9 ☐ Unknow	2 □ No	4□Preg 9□Unki	nant at time of nown	death 5	Other (spec	cify)				MIC	onth	Day Year
<u>ď</u>	that the de led by the a detached f			0.0000032	ions contributing to	leath/but nbt re	sulting in the u	nderivi <b>đ</b> a cal	use aive	n in Part I		23e Did tot	nacco use con	tribute to th	ne cause of death?
Division of Vital Records,	uires tha signed Id be del	Completed by	(5	1P) (F	-PEBR	4/1	eman	211/1	7/6	-/1	993	)	es 2 🗆 No		ably 4 DUnknown
Ö	w requir been s should	lete		1		/			1		(3	24a. Was a	245	More outo	nou findings evaleble
Re	Physician: The lav r this certificate has ral director, page 2	dwo							/			autops perform	ned?	prior to con death?	psy findings available mpletion of cause of
ā	tifical tor. p	0	25. Was case ref	ferred to medica	al					26 Place	of Death	Check only		1 🗌 Yes	2□ No
>	Attending Physician: r death. ector: After this certifice by the funeral director.	To B	examiner?	tero	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA	Othe		rsing Hon	./	ence 6 Oth	ner (Specifi	v)
0	ng Ph fter th neral		27. Manner of De	eath 5 🗌 Pendi	28a. Date	of Injury oth, Day Year)	28b. Time of	28	c. Injury Work		-	8d. Describe ho			
20	eath. or: A	cati	2 Accident		igation			М		'es 2□N	10				
$\leq$	l or Attending Ph after death. Director; After th d in by the funeral	Certification:	4 Homicide		nined 286. Plac	e of Injury - At I ling, etc. <i>(Spec</i>	nome, farm, str ify)	eet, factory,	office		2	8f. Location (St. City or Town	reet and Numb n, State)	oer or Rura	d Route Number,
_	purs a ours a erei (		29a. Certifier	117 Cartifui	na Physician: To th	a boot of my ke	oudodos dosti			- 4-4-					1)
	24 h	edical	(Check only one)	2 Medical	ng Physician: To th Examiner: On the l and mar	asis of examin ner stated.	ation and/or inv	estigation, in	n my op	e, date and inion, deat	h occurre	nd due to the ca id at the time, da	ause(s) and ma ate and place,	anner as st and due to	tated. the cause(s)
	To the Hospitel or All within 24 hours after of To the Funerel Direct completely filled in by	Me	29b. Signature ar	nd title of certifie	4	1		29c.	License	number		2	9d. Date signe	d (Month)	Day, Year)
				·	ian. 1	MAGU	514	-	11	122	04	5	3/1	1/	08-
<i>,</i> ,	, , ,	1	30. Name and ad	Idress of person	wh completed cau	se of death (Ite	m 23a) (Type,	Print)	$\Delta$	11	100	-100.	10010	20	77,71/7
4	1-15			110	MEDIC	A1 (1	HYPU	15 K		1+	H k	77700	MMI	19	01146
	Sta Registra		31. Date filed (Mo	onth, Day, Year, MAR 1 2		gistrar's Sign	ature I								
1	11111			*******	LUUU M	A BOOK OF	11.								1

DHMH 17 Rev 1/2001

# death with the Maryland filed within 72 hours after Hygiene. Baltimore, Maryland 21215-0036 Pages 1 and 2 should be and Mental Department of Health

**Physician** /Medical Examiner certificate be executed

Box 68760,

P.0.

Division or Vital Records,

mportant; If item 27 is marked other

burial-transit attending physician the for use as the cate has been signed by page 2 should be detacl After this certificate funeral director, death.

To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Russell Horner 550 March 6,2008 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico lisburc Salisbury Rehalo+ Nursina Ctr If Under 1 Year | If Under 24 Hrs... Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**⊠**M 2□F 92 216-07-2202 10/1/1915 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County t be notified at 1 ☐ Yes 2 X No Wicomico Bivalve Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21814 USA ortant; If item 27 is marked other than "natural", or items 23a Injury or other traumatic event, the Medical Examiner must k 21245 Nanticoke Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 TNo Specify Specify. ò white 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver trucking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Mae Furbush Edward Henry Horner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21245 Nanticoke Rd., Bivalve, MD 21814 Robert J. Niblett/grandson 20b. Place of Disposition (Name of cemetery, crematory or other place)
WICOMICO Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 TxBurial 2 ☐ Cremation 3 ☐ Removal from State 3/11/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park Signature of Funeral Service HOITOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 TRuf Aa. Part1. Enter the disease, or complication, that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one couse operatory line. Approximate Interval Between Onset and Death disease or condition resulting in death) 2001 Due to (or as a consequence of): er on Sequentially list conditions, if any leading to minimal accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 0 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 2 700 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 🗌 Yes 2 HO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robins, 2. Registrar's Signature 31. Date filed (Month, Day, Year) 0 2008 Registrar

DHMH 17 Rev 1/2001

Chester Elbridge			e of Maryland	/ Depa	rtment of	Health and					~ ~ ~ ~ ~			
Physicia		Registrar  1. Decedent's Name (First, Middle,L	ast)	Cer	tificate or	Death		2. Date of Death	) in the	3. 0 0 0	Time of Death			
Medical Exami			Elbridge J	ackso	n, Jr.			Month March 8, 2	Day Year 008	г	1135 hrs			
S. Con		4a. Facility Name (if not institution, 8655 Ridge Road	give street and numbe	r)		4b. City, Town, or Ellicott City	Location of De	eath	4c. County o Howard	f Death				
Funeral	•	Social Security Number     6.	Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year			h(MM/DD/YYYY)	9. Birthp Foreign	lace (State or			
Director		218 42 1159 t	K M 2 F	61	Yrs	Months Days	Hours	Min. 04/22,	/1946	Coun	try) MD			
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Local	ion				1	0d. Inside City Limits			
d how a	_	MD Howa:	rd		licott						Yes 2 X No			
larylar 8a-f s	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wh	at Countr	y?			
anthe Nation 3a or 2		8655 Ridge Rd				21043			United	l Sta	tes			
th with ems 2.	Funeral	11. Marital Status 1 Never Married 2 Marri	12. Was Deceder Armed Forces		.S. 13. Wa	as Decedent of His es, specify Cubar	panic Origin? , Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	14. Race White		n Indian, Black,			
er dea			1 X Yes	2 No	0 1	Yes 2 x No	specify:		Specify:	Wh	ite			
ours aft ttural'	d by	15. Decedent's Education (Specify	Of Dates.		16a. Decede	nt's Usual Occupat	ion (Give kind		16b. Kind of Bu					
6 172 ho an "ng	lete	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	dunng n	nost of working life	. DO NOT USE	e retired)						
003 within giene.	Completed	12 17. Father's Name (First, Middle, La			B	arber _	18 Mother's N	lame (First, Middle, N	Barber		р			
215- e filed ked oth	MD Howard Ellicott Complete Body with the Mary Body Body Body Body Body Body Body Bod							Cecelia Ensev						
21; ould b d Men s mar tic eve	P 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Ro									n, State, Z	Zip Code)			
MD nd 2 sho alth and m 27 is		Linda R. Jackson 20a. Method of Disposition	n/Wife	Look		Ridge Rd		ott City,	MD 2104		own State			
Baltimore, permit. Pages I al Department of He Important: If ite		1 X Burial 2 Cremation	3 Removal from S	State	crematory or o	ther place)				•				
Itim it. Pag rtment rtant: y or o		4 Donation 5 Other Special Signature of Funeral Service Lie		M010		n Mem. G		3-13-2008			ille, MD ly FH Inc.			
Ba perm Depa Impo injur		Then Olens	retty	L'INSERT				a Pike El						
Physician		23a. Part I. Enter the disease, or co failure. List only one cause or		ed the death	. Do not enter	the mode of dying,	such as card	iac or respiratory arre	est, shock, or he	art	Approximate Interval Between Onset and			
/Medical xaminer		Immediate Cause (Final disease	Indeed and assemble of constant											
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.												
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence o	of):									
-	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence o	of):									
executed an and al - transit		- unincuped	d					<u> </u>						
<u>a a a</u>	ledic	UNPENDED  IF FEMALE:	23c. If yes, outc	come of pred	nancy				23d. Date of	f delivery				
Ox 68760, leath certificate be e attending physici for use as the buri	cian/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 F	etal death 3	Ectopic pr	regnancy	Month	Da	ay Year			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	/sici	1 Yes 2 No 9 Unknown		at time of d	eath 5 C	other (Specify)								
O. Bonat the desirable by the	y Physic	Part II. Other significant conditio	ns contributing to de	ath but not	resulting in the	underlying cause	given in Part I				ne cause of death?			
s, P.O. irres that the signed by a detach	ed by							_ 1	s 2 🗸 No 3					
cords, law requi has been s	Completed						-	24a. Was autop	sy		opsy findings available impletion of cause of			
tal Rec ician: The l certificate l	Com							1 🗸 Yes		<b>✓</b> Yes	2 No			
ital iician: s certi irector	Be	25. Was case referred to medical examiner?	Hospital:	itient 2	ER/Outpatier		Othor:	neck only one)	Residence 6	✓ Other:	Scene			
1 of Vital Records, ing Physician: The law requir After this certificate has been s tuneral director, page 2 should	7. To	1 Yes 2 No 27. Manner of Death	28a Date of I	Dille	28b. Time of		ry at Work?	28d. Describe	how injury occur					
ion tendin eath. lor: A the fu	atior	1 Natural 5 Pendir 2 Accident Investi			FOUND: 1127 hrs	1	Yes 2 🗸 N	。 Subject sho	it seii					
Division tal or Attendi rs after death. al Director: /	Certification:	3 ✓ Suicide 6 Could determ	not be 28e. Place of		nome, farm, str	eet, factory, office	building, etc.	28f. Location ( or Town, S	Street and Numb State) Road, Ellicott C	per or Rur	al Route Number, City			
Division of 1  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		29a. Certifier	sician: To the best of		dae death occ	urred at the time of	late and place				d			
To the II within 24 To the F complete	Medical	one) 2 Medical Exam	iner:On the basis of e	xamination	and/or investig	ation, in my opinio	n, death occur	rred at the time, date	and place, and	due to the	cause(s)			
T viji v	Me	29b. Signature and title of certifier	/ /			29c. Licen			29d. Date sign		th, Day, Year)			
			he Jei			O.C	.M.E.		March 9, 2	2008	-,,			
(10) N2		30. Name and address of person water Tasha Greenberg MD.	ho completed cause of Assistant Med			l Penn Street,	Baltimore	e, MD 21201						
	tate	31. Date filed (Month, Day, Year)	0	trar's Signa		and a								
Regis	trar	MINU T T	LUUU JAKA	ELAS.	75. Pag									

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Division or Vital Records, P.O. Box 68760,	To the Unesited or Attending Divisions. The law requires that the death certificate he executed
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F	3+
E	

	1 - State Registrar		C	ertificate of	Death		eg. N6.)	0.8	0933	
ian ical	Decedent's Name (First, Middle,     FREDERICK W. I					2. Date of Dear	08 08	2008	3. Time of Death 1927 P	
iner	4a. Facility Name (If not institution,	give street and nymber)	antel	4b. City, Town, o	r Location of Death			ty of Death	co	
	5. Social Security Number 217-76-3942	5. Sex 7. Age (In yrs 1 ☑ M 2 ☐ F 47	s. last birthda Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 9-28-19	Year) 960	9. Birthp Cour MARY	place (State or Fore htry) LAND	
	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or	Location				1	0d. Inside City Limi	
Director	DELAWARE SUSSEX	ζ	SELBY	YVILLE			- 011		1 □ Yes 2 🛣 I	
i Dir	10e. Street and Number 38993 BAYVIEW V	VEST		10f. Zip Code 1997	5		0g. Citizen o	r what Cour	itry?	
To Be Completed by Funeral Director	11. Marital Status  1 X Never Married 2  Marrie 3  Widowed 4  Divorced	12. Was Decedent Ever in Armed Forces?	U.S. 1	3. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- D Rican, etc.)	14. Ra	ace - Americ ack, White, ify: WH		
eted t	15. Decedent's (Specify only highest	Education	1 (G	cedent's Usual Occupive kind of work done	during most of work	king	16b. Kind of	Business/In	dustry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	e. DO NOT use retire LE MAINTEN.			TELEI	HONE	COMPANY	
Be C	17. Father's Name (First, Middle, La				18. Mother's Nam	ne (First, Middle,	Maiden Surna	ame)		
2	FREDERICK W. K		T			YN ANN I				
	19a. Informant's Name/Relationship CHARISSA JOACHIM			ailing Address (Street LAGOON)					•	
	20a. Method of Disposition	20h	Place of Di	sposition (Name of	i	Date	20c. Location			
	1 ☐ Burial 2 🖫 Cremation 3 4 ☐ Donation 5 ☐ Ottle (1996)	3 □Removal from State M ecify H	ELSONS ENLOPI	rematory of other pla EN CREMATO	RY 3-10	-08 I	RANKFO	ORD, D	ELAWARE	
	21. Signature of fun (al Service Li	icensed	1	22. Name and Addre	ERAT. ŠERV	ICES,LTI	).			
	23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that caused the dea	14	43 THATCHE	R ST, FRA	NKFORD,	DELAWA	ARE. 1	Approximate	
	Immediate Cause (Final			DATHY					Interval Between Onset and Death	
	disease or condition resulting in death)	a. Due to (or as a conse			1000					
<b>1</b>	Sequentially list conditions if any leading to immediate b. Due to (or as a consequence oi).									
Examiner	cause. Enter Underlying Cause (Disease or injury  Case (Labor April Apri									
	resulting in death) Last  Due to (or as a consequence of):									
dical	d									
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		1	Date of deliv	ery Day Year	
by Ph	Part II. Other significant condition	ns contributing to death but not re	esulting in th	e underlying cause giv	ven in Part I.	23e. Did to	bacco use co	entribute to t	he cause of death?	
						1 🗆 Y	es 2⊿No	3∏ Prol	bably 4 ☐Unkno	
Completed						24a. Was a autop perfor	sy	o. Were auto prior to co death?	opsy findings availa impletion of cause	
	25. Was case referred to medical				OC Plans of Dag	1□ Yes	2 No	1 ☐ Yes	2□ No	
To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpa	tient 3 DOA Otl	oor:	ith <i>(Check only or</i> Iome 5 ☐ Resid	,	ther (Speci	fy)	
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ry Wo		28d. Describe h	ow injury occ	urred		
icati	2 Accident investigated as Suicide 6 Could not	ation	home, farm.		]Yes 2□No	28f Location (S	treet and Nu	mber or Run	al Route Number,	
Certification:	4 ☐ Homicide determin	building, etc. (Spec	cify)	,,, ,		City or Tow				
Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my k examiner: On the basis of exami and manner stated.	nation and/o	or investigation, in my	opinion, death occu	irred at the time,	date and plac	manner as s e, and due t	stated. to the cause(s)	
	29b. Signature and litle of certifier	WIM MD.		29c. Licen	se number		29d. Date sign	ned (Month,	Day, Year)	
M	Fugue	eviz .			146536		03/0	20/20	28	
Me				F.	7 1 7 7 2		03/	10/00		

DHMH 17 Rev 1/2001

Box 68760 P.O. | Division or Vital Records,

To the Hospita wwithin 24 hours after death.

To the Funeral Director: After a consistent of the funeral Director of the funeral of the funer

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 0 7 2008

Superich RSM, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Suparich, MD 1500 Forest Glen Rd Silver Spring, MD 20910

32 Registrar's Signature

1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D0065485

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day <u>10:</u>35 P<sup>M</sup> Kalavitinos March 2008 W. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 □ M 2 🖾 F DC 1/7/1925 578-30-6980 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 √ Yes 2 No Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 United States 2953 Terrace Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2K No Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government/ Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Executive Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Woodhouse Rose Zerega 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Bailey Court Bridgewater, NJ 08807 Jeffrey Lynn Mullikin / Nephew Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State National Crematory 3-6-08 Falls Church, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signatur of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dehydration Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Metastatic Breast Cancer Due to (or as a consequence of): 3d. Date of delivery Year Month Day se contribute to the cause of death? No 3□ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ☐Other (Specify)

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit

**Physician** 

/Medical

Examiner

Funeral

Director

or 28a-f show o notified at

ns 23a or ? must be r

ral", or items 2 Examiner mu

Medical

"natural"

other

t. Pages 1 and 2 should be filed w trment of Health and Mental Hygie rtant: If item 27 is marked other t njury or other traumatic event, t<u>i</u>

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other th once.

Directo

Funera

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Completed

Be

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Examir Physician/Medical signed t δ Be Completed ဥ Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

(	d	
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖾 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Yes
25. Was case referred to medical	26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 DOA   Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year) MAR 0 7 2008

namalia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D60826

29d. Date signed (Month, Day, Year)

03/04/2008

• • •		Please Type or Print in Blac			-	_	
	4	State of Maryland /				7000	09336
		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of	Death	Reg. N  2. Date of Death	0	3. Time of Death
Physician	n	George Euge	ne Kline		Month D	ay Year	0157 M
/Medica Examine	-	4a. Facility Name (If not Institution, give street and number)	4b. City, Town, o	Location of Death		c. County of Death	
		University of Maryland	BQ H	more If Under 24 Hrs.		Baltimor	
Funeral Director	1	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last t</i> )  219-34-5661 1 1 2 F 72	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea June 17,	r) Col	nplace (State or Foreign untry) Maryland
	- 1	Usual Residence of Decedent			oune 17,	1733	
larylan show ed at			wn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	# H	Maryland Frederick  10e. Street and Number	Smith:	sburg	10a. C	Citizen of What Co	untry?
		13326 Brandenburg Hollow Road		783		U.S.A.	•
ems 2	runeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
s after	יין (מ	1  Never Married 2  Married 1  Yes 2  No If Yes, Give 3  Widowed 4  Divorced Year or Dates:	1 ☐ Yes 2 ▼ No	Specify:		Specify:	White
tural sal Ex		15. Decedent's Education 16	 Sa. Decedent's Usual Occup	ation	16b.	Kind of Business/l	
e. Ran "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of workir d)	ng		
ygien ygien t, the	5 -	7	Farmer	40 Mathada Nasa	(Final Asiatala Asiata	Agricul	ture
ntal H ed oth	ŏ	17. Father's Name (First, Middle, Last)  Arthur Kline			(First, Middle, Maide Brandenb	- i	
should Me mark imaric	2		9b. Mailing Address <i>(Street</i>				(ip Code)
and 2: alth al		Peggy A. Kline (Wife) 1	3326 Branden	burg Hollo	w Rd. Smi	thsburg,	MD 21783
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any finy or other traumatic event, the Medical Exonce.	-	20a. Method of Disposition 20b. Place cene 1 Transparent 2 Ceremation 3 Removal from State Garfice	of Disposition (Name of tery, crematory or other place ed United	ce) March	ate 21, 20c.	Location - City or	Town, State
Pag tment tant: I		4 □ Donation 5 □ Other (Specify) Method	dist Cemeter	, 200			, Maryland
permit Depar Impor any in		21. Signature of Funeral Service Licensee	22. Name and Addre		L. Davis		
	4	23a. Part1. Enter the disease, or complications that caused the death. Do				rg, mary.	Approximate
Physician		shock, or heart failure. List only one cause on each line.					Interval Between Onset and Death
/Medical			,	i ici ca	, , ,		
Examiner		Sequentially list conditions, b. Intraabc	dominal	Sep	Sis		
red Isit	Ехашпе	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e oi):				
be executed ician and burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence	e of):				
Ficial be		d					
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome pf pregnancy	·				
attend for us	clan	in the past 12 months?		4		23d. Date of deli Month	Day Year
at the de by the	ı ysı	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown					
res that signed be det	Dy P	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause giv	en in Part I.			the cause of death?
w require					1 🗆 Yes		obably 4 □Unknown
e law has b	Сотріете				24a. Was an autopsy	24b. Were au prior to death?	topsy findings available completion of cause of
		25. Was case referred to medical		OC Disease of Death	performed	No 1 ☐ Yes	2 □ No
ysicla s certi	10 De	exammer?	Outpatient 3 DOA Oth	26. Place of Death er: 4□ Nursing Hor	ne 5 Residence	6 □Other (Spec	cify)
ng Phys ter this oneral dir		27. Manuar of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b.	o. Time of 28c. Injury Wor		28d. Describe how in		
tendir eath. for: A	Certification:	2 ☐ Accident investigation		Yes 2 □ No			
or At after d Direct in by		3 Suicide 4 Homicide  4 Homicide  4 See. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	2	28f. Location (Street City or Town, Sta		iral Houte Number,
Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowled					
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occurr			
To t COM	Σ	29b. Signature and title of certifier	29c. Licens		29d. [	Date signed (Monta	h, Day, Year)
		6 7 MD		22206		3/18/08	
		30. Name and address of person who completed cause of death (Item 23a ADRIAN MAUNE MD. 22 S	S Greene	Street	Bal	to . N	ID 21201
State	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	S Greene	<u> </u>			
Registra		MAR 2 4 2008 France &	Good .				
DHMH 17 Rev 1/200	)1	9	ORIGINAL				

		Please					Ensure A	_		_		
		For State Registrar	State of	Maryland ,		rtment of F tificate of	lealth and N <i>Death</i>		giene Reg. No.	the party print print	09337	
		Decedent's Name (First, Middle, Las	st)					2. Date of Dea	ath		3. Time of Death	
Physicia		Barbara	Α.	Koehle	r			Month	Day		12:56 P <sup>M</sup>	
/Medica Examine	100	4a. Facility Name (If not institution, give		per)		4b. City, Town, o	r Location of Death		4c.	County of Death		
		Shady Grove Adver	ntist Hos	spital		Rockv			N	lontgome		
Funeral		5. Social Security Number 6. S		. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)		place (State or Foreign ntry)	
Director		340-26-0730		74	Yrs.			May 3,	1933	3   I11	inois	
and *	- }-	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limits	
Maryl. f sho	5	1 1 Nombron		Воу	da						1 ☐ Yes 2 No	
the 1	A. 1	Maryland   Montgon  10e. Street and Number	пету	воу	us	10f. Zip Code			10g. Citi	zen of What Cou	ntry?	
3a or		18132 Truffle Lan	۵			2084	1			USA		
ms 2	Funeral	11. Marital Status		ent Ever in U.S.	13. V		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	)-	14. Race - Ameri Black, White		
after or ite		1 Never Married 2 Married	1 Yes 2	No No		Yes 2K No	Specify:	or mount, oro.,		Specify:	610.	
ours ral",	g	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:						W	nite	
72 h "natt	ete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	1	16a. Deced <i>(Give l</i>	ent's Usual Occup kind of work done	pation during most of work d)	king	16b. Kii	nd of Business/Ir	dustry	
within sne.	g I	Elementary/Secondary (0-12)	College (1-4	4or 5+)		memaker	uj			Home		
filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Be Completed	17. Father's Name (First, Middle, Last)			по	memaker	18. Mother's Nam	ne (First, Middle,	, Maiden			
d be ental	ă	Theodore		erry			reese					
2 should be and Mental is marked craumatic even	၉	19a. Informant's Name/Relationship (			19b. Mailin	g Address (Street	and Number or Ru	Grace  ural Route Numb			p Code)	
nd 2 sulth ar		Traci Koehler Joh	nson/Dar	ohter 1	8132	Truff1e	Lane, Bo	vds, Mai	ry1aı	nd 20841		
s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of natory or other pla		Date		ocation - City or T		
Pages nent of ant: If it any or o		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Specif</i>		tate			i .	0/2008	Ale	xandria	, Virginia	
교수관등	_	21-100 ture of Funeral Service Licer	isee 0	00		, Name and Addre		eVol Fun				
permit Depar Impor any ir		Moderal of	1 les	lilly						sburg, 1	MD. 20877	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that car one cause on ea	used the death. ch line.	Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition		atory F	ailur	P					Onset and Death	
/Medical		resulting in death)		r as a consequer		,						
Examiner	.	Sequentially list conditions b. Cardiac Arrest										
D #	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	r as a consequer								
executed n and ial-transit	cam	Cause (Disease or injury that initiated events resulting in death) Last	Ų.	ratic Lu		ncer						
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cate I	<u>ö</u>		Ld. POSL C	DSLIUCL	IVE I	neumonia						
eath certificate be e attending physician for use as the buris	Me	IF FEMALE:	23c. If yes, outc	ome pf pregnanc	·v					23d. Date of deli	verv	
atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	nth 2 ☐ Fetal do ant at time of dea	eath 3	Ectopic pregnand Other (specify) _	ey			Month	Day Year	
the d y the ched	Physician/Medical	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□Unknov									
Attending Physician: The law requires that the death certificate be reach. ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	F P	Part II. Other significant conditions	contributing to dea	ath but not resulti	ng in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?	
puires n sign lld be	d by	COPD						1 🔀	Yes 2	□ No 3□ Pro	obably 4 Unknown	
w require been sign	Completed							24a. Was		24b. Were au	topsy findings available	
he lav e has age 2 :	mc								opsy ormed? 2⊠No	death?	ompletion of cause of 2 ☐ No	
an: T tifficat tor, pa		25. Was case referred to medical					26. Place of Dea			7 12 100	20110	
ding Physician: The n. After this certificate ha funeral director, page	o Be	examiner? 1  Yes 2  No	Hospital: 1 🔀 In	patient 2 EF	R/Outpatien	t 3 DOA Oti	hor:			6 □Other (Spec	cify)	
g Ph	Ë	27. Manner of Death	28a. Date of	f Injury 2.	8b. Time of Injury	28c. Inju Wo	iry at	28d. Describe	how inju	ry occurred		
ath. or: Af	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n	, ==, . ==,			]Yes 2□No					
r Atte er de recto by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	≥oe. Place u	of injury - At home g, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location ( Cify or To			ral Route Number,	
Ital or rs after al Div	Cer							1				
		(Check only 2 Medical Exa	mor: On the ba	sis of examinatio	edge, death n and/or in	n occurred at the t vestigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time	e cause(s , date an	and manner as d place, and due	stated. to the cause(s)	
the I	Medical	one)	and manne			29c. Licen				ate signed (Monti		
5 ¥ 5 70 N	-	29b. Signature and title of contifier	7.20	-		200. Licell	(1/5		_Ju. Da	organica (intotal	.,,,	

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

29c. License number

March 4, 2008

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockville, Maryland 20850 Shahryar Davari, M.D., 31. Date filed (Month, Day, Year) MAR 1 0

State Registrar



10

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

MAR 1 0 2008

. Registrar's Signature

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Democray Blud, Belsterder, 20

	1	For State Registrar		State o	f Marylar		artmen rtificat			nd Me	•	giene Reg. No.	2008	ng	339
Physician		1. Decedent's Name (First, M Janet				Law	son				2. Date of De Month	eath Day	Year	3. Time of	. M
/Medical Examiner		4a. Facility Name (If not instit	ution, give s	treet and nu	m <i>ber)</i>			Town, or	Location of D		larch_	4c. (	2008 County of Death	7:15	Α "
Funeral Director	ı	Arden Courts 5. Social Security Number 087-07-1221	6. Sex		7. Age (In yrs.	last birthday) Yrs.	Kens If Under Months		If Under 24	Min.	B. Date of Bir (Month, Da 06/20/	th ay, Year)	9. Birth Coun New	olace (State o	or Foreign
show ed at	Ī	Usual Residence of Deceder 10a, State 10b. Co DC				ty, Town or Lo							and the second s	10d. Inside Ci	ity Limits
ifter death with the Mar r items 23a or 28a-f sl iner must be notified		10e. Street and Number 2410 - 20th	Street	NW			10f. Zip 200						en of What Cou		
urs a	2	11. Marital Status 1 □ Never Married 2□ 3 ☑ Widowed 4 □ Divo	Married	2. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 X No ve		Was Deced If Yes, spec	_	spanic Origin n, Mexican, F Specify:	n? (Speci Puerto Ri	ity Yes or No ican, etc.)		4. Race - Americ Black, White, Specify: White	etc.	
ed within 72 hor lygiene. ner than "natura it, the Medical E	nubicier.	15. Dec (Specify only h Elementary/Secondary (0-		cation completed) College (		(Give	dent's Usua kind of wor DO NOT us Make1	k done di e retired)	urina most o	of working	7		nd of Business/In	dustry	
Mental Hygi Mental Hygi arked other atic event, t	3	17. Father's Name (First, Mid John M. Lough	,						18. Mother's Betty	_ `.	First, Middle hreibe	•	Surname)		
l and 2 sho lealth and l m 27 is ma her trauma		19a. Informant's Name/Rela Betty L. Doo				736	Tiffar	y Co	urt G		ersbui	g, M	Town, State, Zip D 20878 Cation - City or T		
mit. Pages ' bartment of h bortant: If ite r injury or of		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremat  4 ☐ Donation 5 ☐ Oth  21. Signature of Funeral Set	er (Specify)		State	Place of Dispo cemetery, cre ington 2	Nat.	Cem	et. 03/	/18/2	2008	Arliı	ngton, V	irgini	.a
Imp any any		> Will-a	y K	. Bu	ype	51	130 Wi	scon	sin Av	ve.	NW Was	hing	ton, DC	20016	
Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	e, or compli List only on	Due to	carsed the dealeach line. pertens (or as a consecution ary (or as a consecution as a consecution ary	ive Ca: quence of): Artery	rdiova	ascul	Lar Di	seas	e	arrest,		Approxima Interval Be Onset and	ween Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Contributed by Diversities in To Bo Completely the Diversities in the page 2 should be detached for use as the burial-transit medical Contributed by Diversities in the page 2 should be detached by Diversities in the Diversities in th	5	if any, leading to intraediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		(or as a consec	•							9		
w requires that the death certifical been signed by the attending phy should be detached for use as the physician Model.	y sicial time	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 ☎ No 9 □ Unknown	it	1 Live	atcome pf pregr birth 2 ☐ Fet nant at time of nown	ai déath 3í	□Ectopic pi □ Other (sp					2	23d. Date of deliv		Year
equires that some ban signed band be deta	2	Part II. Other significant co	nditions cor	tributing to d	leath but not re	sulting in the u	underlying c	ause give	n in Part I.				se contribute to ☑ No 3 ☐ Pro		
sician: The law requii certificate has been s irector, page 2 should	odulos												24b. Were aut prior to co death? 1 ∐ Yes	opsy findings ompletion of o	available ause of
ysician: s certific director,	2	25. Was case referred to me examiner? 1 ☐ Yes 2 ☒ No	1	lospital:	Inpatient 2	] ER/Outpatie	.nt 2 🗆 D	Othe	r.		Check only		7 Flort /0	7.E. A.	
ttal or Attending Physician: rs after death. ral Director: After this certific led in by the funeral director,	1	27. Manner of Death  1 X Natural 5 Period in	ending vestigation ould not be	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	of 2	8c. Injury Work 1 🔲 Y		0 28	3d. Describe	how injur			
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification.		4 ☐ Homicide de	etermined	build	e of injury - At h ling, etc. (Spec e best of my kn	ify)			ne, date and		City or To	wn, State	d Number or Rui		nber,
the Hosp in 24 hou the Fune plettely fil	2			ner: On the b									l place, and due		s)
Veithin South		29b. Signature and title of ce	المند	yon	0-1	H.D.		. License 0-276	560			29d. Dat	e signed (Month	, Day, Year)	
		30. Name and address of pe		/ [	se of death (Ite 10 Rock			-	a Gosw	ami	MD				
State		31. Date filed (Month, Day,		1	Registrar's Sigr		acts 1								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 0922 PM March John Cleggett Lung /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Washington County Hospital 5. Social Security Number | 6. Sex | 7. Age (In vrs. le Hagerstown If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 10X M 2□F Days Months 88 Dec.17 Maryland Director 215-36-7157 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at Washington a or 28a-f sho 1 TYes 2 No Director Hagerstown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20511 Leitersburg Pike 21742 items 23a "natural", or Items 23a Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛣 No <u></u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Dairy Farmer 8 permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Martha Paulsgrove Lung Cleggett Bishop Lung 19b Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742 19a. Informant's Name/Relationship (Type. Print) John Lung-son 20b. Place of Disposition (Name of centerly corpustory or other place) St. Paul Is Lutheran Cemetery 3-13-2008 Leitersburg, Marylan 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas 1331 Eastern Blvd. North Fiery Funeral 21. Signature of Funeral Service Licenses Hagerstown, MD 21742 (23a. Part 1. Enter the disease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate set and Deat Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner HBAICCATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (or as a conseque Examiner as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy for Month Day Year in the past 12 months? 5 ☐ Other (specify) I□Yes 2□No 9 ☐ Unknown ģ signed to Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 certificate Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Tes 2**2 N**o 1 Inpatient 3□ DOA P this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation **1** □ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed P.O. Box 68760, Records, Division or Vital

Baltimore, Maryland 21215-0036

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

2511-45

State Registrar

Medical

2008

4 Homicide

(Check only

29a. Certifier

29b. Signat

30. Name

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Registrar	Depa Ce	artment of Heartificate of De	alth and N eath		giene (	800	09341
dis	% 9	1	Decedent's Name (First, Middle, Last)				2. Date of De			3. Time of Death
	Physici		Peggy Lou Martin				Month March	7, 20	08 <sup>Year</sup>	6:00 A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cation of Death			nty of Death	
		9	Casey House		Rockville			Mont	gomery	7
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1 1 M 2 F 54	oirthday) Yrs.		Hours Min.	8. Date of Bir (Month, Da Nov 10	v. Year)	Cour	place (State or Foreign otry) Land
	- Jo		Usual Residence of Decedent							
	aryla shov	<u>_</u>	10a. State 10b. County 10c. City, To		cation				'	0d. Inside City Limits 1 ☐ Yes 2 No
	he M 28a-f otifie	Director	MD Frederick Monrov	ia	10f. Zip Code			10g. Citizen o		
	with a or	ä	12103 Hardrock Circle		21770			USA	or winat Cour	uty?
	feath mus	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Sp	ecify Yes or No		lace - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	Armed Forces?  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  Armed Forces?  1 □ Yes 2 Mo If Yes, Give Year or Dates:			Mexican, Puèrto <i>Specity:</i>	Rićan, etc.)		lack, White, <sup>cify:</sup> Wh <b>i</b> t	
21215-0036	2 hou latura	ted		a. Dece	dent's Usual Occupatio	n			Business/In	
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7	ed wi ygien her th t, the	S		mema	aker			Own Ho		
Maryland	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last)			3. Mother's Nam	, ,		ame)	
3	ould d Mer narke	၉	Douglas Richard Beach	h h a 111		eautis M				
<u>N</u>	d2sh than 7 is n traun				ng Address (Street and					Code)
	1 an Heal tem 2		20a Method of Disposition 20b, Place	of Dispo	B Hardrock sition (Name of		Monrovi Date		21//U n - City or To	own. State
ΘĽ	ages ent of rt: If it				matory or other place) ke Cremator	·v 03/0	18/08	Beltsv		,
altimore,	nit. F		21. Signature of Funeral Service Licensee	-	2. Name and Address of Home C	-			_	_
m	Der		Develo I He Uto MO125							MD 21029
	¥ . Suge		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.						O V ALL L	Approximate Interval Between
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6	LAdillilei	<u>_</u>	Sequentially list conditions, b.	6\						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	9 01):						
	execu al-trai	Examiner	that initiated events resulting in death) Last C Due to (or as a consequence	e of):						
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9	tificat ig phy as th	ledí								
. Box	leath certific attending p	M/ue	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea	th 3F	Ectopic pregnancy				Date of delive	*
Ш	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	by Physician/Me	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Yes 3 □ The large and a time of death		Other (specify)				Month	Day Year
<u>о</u>	ires that the de signed by the a l be detached t	Phy	Part II. Other significant conditions contributing to death but not resulting	in the 11	nderlying cause given it	n Part I	23e Did t	obacco usa co	antribute to ti	ne cause of death?
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So	w require been si should b	etec					24a. Was			
Ř	he lav e has	Completed					autor		prior to co death?	psy findings available mpletion of cause of
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	ysicia s cer direct	O B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	utpatier					Other (Specif	y) hospice
0	ding Phys h. After this funeral di	L :u	(A 4 - 44 D - 1 / 4 1)	Time o			28d. Describe			,, .
000	Attending death.	atio	2 Accident investigation	,,		3 2 □ No				
Division or	or Atterdering Inected	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury · At home, building, etc. (Specify)	arm, str	eet, factory, office		28f. Location (S City or Tox	Street and Nui vn, State)	mber or Rura	al Route Number,
	Hospital or Attend 4 hours after death. Funeral Director: A ely filled in by the f		A CONTRACTOR OF THE CONTRACTOR							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, g	Medical	29a. Certifier 1 A Certifying Physician: To the best of my knowled (Check y 2 Medical Examiner: On the basis of examination and manner stated)	je, deat ind/or in	vestigation, in my opini	date and place, ion, death occur	and due to the red at the time,	cause(s) and date and place	manner as s e, and due to	tated. the cause(s)
	o the	Mec	29b. Signature and title of certifier		29c. License nu	ımber		29d. Date sig	ned (Month,	Day, Year)
	->=0		Avenous like ( Jos a)		D64615			March	7, 200	)8
	000		30. Name and address of person who completed cause of death (Item 23a	(Type,	Print)					_
9	/ V~"		Genevieve Wroblewski, M.D. 6001 M	unca	aster Mill	Rd. Roc	kville.	MD 20	855	
8	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					77-		
	Registr	ar	MAR 1 1 2008 Seem &	10	08481					

DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2 1 1 8 19342													
			Registrar  1. Decedent's Name (First, Middle	/ not)		Cei	rtificate of	Deatr	) 	2. Date of De	Reg. No	2000	3. Time o	J 4 Z
	Physici	_	MARY B		URPHY	7				Month	25 ,	2008 Year		58P <sup>M</sup>
-	/Medic	_	4a. Facility Name (If not institution			_	4b. City, Town,	or Location				. County of Dea		301
E .			Holy Cross	-			Silve					Montgo		
b	Funeral Director		5. Social Security Number 217-44-0312	6. Sex 7. A 1 □ M 2 🖾 F	Age (In yrs 89	last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bird (Month, Da Feb. 2	th ly, Year 26	9. Bir Co	thplace <i>(State</i> ountry) <b>[aryla</b>	
	D 199		Usual Residence of Decedent							160.2	.0,3			
	arylan show d at	-	10a. State 10b. County		10c. City	y, Town or Lo							10d. Inside 0	City Limits 3 2 □ No
	the Mi 28a-f	ecto	MD Mon	tgomery		Wheat	10f. Zip Code				10a Cir	tizen of What Co		
	3a or	<b>Funeral Director</b>	2619 Kensin	gton Blvd			1 '	902			-	J.S.A.	· · · · · · · · · · · · · · · · · · ·	
	death	nera	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic O	rigin? (Spe	ecify Yes or No		14. Race - Ame Black, Whit		
36	filed within 72 hours after death with the Maryland Hygliene. ther than "naturai", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marri		¶No		1 □ Yes 2 <b>X</b> N			· nod., otol,		Specify: B		
21215-0036	thour atural	ed b	15. Decedent	t's Education	·-	16a. Dece	dent's Usual Occ	upation		1	16b. K	(ind of Business	/Industry	
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aryl	10a. State   10b. County   10c. City, Town or Location   10d. City, Town or Location   10d. State   10d. County   10d. City, Town or Location   10d. City In Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City, Town or Location   10d. City In Location   10d. City Town, State, In Location   10d. City In Location   10d. City In Location   10d. City In Location   10d. City In Location   10d. City In Location   10d. City In Location   10d. City In Location									Zip Code)				
	1 and 2 Health a em 27 is		Clifton Burg	ess-Nephe			Parker	. Ave	Wh∈	aton,		20902		
ore	Pages 1 nent of He int: If iten iny or oth		20a. Method of Disposition  2 ☐ Bural 2 ☐ Cremation	3 □Removal from Sta		emetery, crei	sition (Name of matory or other p	lace)		Date		ocation - City or	,	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Condition 5 ☐ Other (S <sub>1</sub> 21. Sig laters of Funeral Service		1	rklaw	n Mem 2. Name and Add	ross of Easi	3/4/		Ro	ckvill	e, MD	ĎΛ
Ba	permit Depar Impor any ir once.		21. Signature of Furieral Service	X X Mall	et	2	46 N. V	Vashi	ngto	n St	Roc	kville	,MD 20	850
	576		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the deat	Do not ent	er the mode of d	ying, such a	s cardiac	or respiratory a	rrest,		Approxima Interval Be	etween
1	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ASCVD  Due to (or as a consequence of):											
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a conseq	uence of):					_			
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unicase of Injury that initiated events	с										
,0928	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or a	as a conseq	uence of):								
687	ficate physi s the b	edical		d										
Box	h certi ending use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne pf pregna	ancy	∃Ectopic pregnar	NOV.				23d. Date of de	,	
	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknown	at time of d		Other (specify)					Month	Day	Year
P.0	that the		9 ☐ Unknown  Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying cause	jiven in Parl	: I.	23e. Did t	tobacco	use contribute t	o the cause of	death?
Records,	quires than signed I	d by								10	Yes 2	2 <b>∑</b> No 3□ P	robably 4	]Unknown
The state of the s														
25. Was case referred to medical examiner?									•	cause or				
Ö	Hospital: 1   Inpatient   2   ER/Outpatient   2   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)									ecify)				
ion	Attending I r death. ector: After by the funer	ation	XXNatural 5 ☐ Pending 2 ☐ Accident investig	9	Day Year)	Injury		orƙ? ⊒Yes 2[				,		
Division	or Attendater death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	200, Flace UI	injury - At ho	ome, farm, str	reet, factory, offic	е		28f. Location ( City or To	Street a	and Number or Fi te)	lural Route Nu	mber,
	pital o		29a. Certifier 1 X Certifyin	ng Physician: To the be	et of my kno	wladna dast	h occurred at the	time date	and place	and due to the	causoli	s) and manner s	e stated	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		Examiner: On the basis and manner	of examina									e(s)
	To th withir To th comp	Me	29b. Signature and title of certifie		110		100	nse number	,			ate signed (Mon		
	0		> Laynord	Mut 1				3539 			Fe	b. 25,	2008	
	-		30. Name and address of person Raymond Whit					റമർ 9	3 i 7 vz	ar Cnr	ina	, MD J	0070	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Regi	strar's Signa	ature	oren K	ouu i	V	-r phr	<u> 1110</u>		03TO	
	Registi	rar	MAR 07	2008	ARA A	K do	CARL!							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MARCH 15, DOROTHY RUTH MURPHY 2008 1:30 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Hospital Chestertown Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 20 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ) 1922 Pennsylvania 1 □ M 2**X**□ F 86 169-14-4346 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hygiene, "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No MD Kent Rock Hall Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5732 S. Hawthorne St. U.S.A. 21661 **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 should be filed w h and Mental Hygie 7 is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert A. Schoonover Hannah Jane Platt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.3
Department of Health an Important: If item 27 is any injury or other trau Albert A. Murphy (son) 84 Edward Lane Lothian, MD. 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 3/19/08 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD, 21635 M00510 23a. Ranti. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure. List only one cause on each line.

Immediate Clise (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** few months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Properal Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1111Mun, MD

Registrar

State

ORIGINAL

415 Washington Ave, Chestortown, MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DX

7 DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 09345 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 8, 2008 **Physician** MOATS KENNETH WARREN 2250 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18119 Manor Church Road Boonsboro Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Norths Days | Hours | Min. | Oct 18, 19734 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 214-32-4379 1**∑**M 2□F Pennsylvania 73 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 27 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Exercities must be multified at 1 Tes 2 No Boonsboro Directo Maryland Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18119 Manor Church Road 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within in and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Chemist Mfg. Cement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Leslie Moats Mary Ellen Lambert 70 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Depertment of Health and Important: If Item 27 Is in any Injury or other traum once. Judy L. Humphrey Daughter 307 Lanafield Circle, Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Manor Church Cemetery 03-13-08 Tilghmanton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie nsee 22 Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietan Street, Hagerstown, Rhoel Brady Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumoma Physician 2 NKS /Medical Due to (or as a consequence of) Examiner Stroke YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner The law requires that the death certificate be executed burial-transit Discorr Due to (or as a conseq Ince of): aven and the attending physicien Hypertension Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vaicular Diccare cate has been sig , page 2 should b 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Be director 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No I Director: d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or Al within 24 hours after or To the Funeral Directions 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44996. March 10, 2008. 30. Name and address orperson who completed cause of death (Item 23a) (Type, Print), Cappans Rd Boomsbno Mb 21713,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 2 2008

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

ORIGINAL

32. Registrar's Signature

5 MH)

State Registrar 31. Date filed (Month, Day,

NO

100 E CARADIL St. SAlisbury Mcl 21801

death (Item 23a) (Type, Print)

who completed cause

2008

Certificate of Death

Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician Joanne Longfellow Marteny 1126 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL MEDICAL Wicenero (ENTER DALISBURY ENINSULA if Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F Hours 218-34-7839 69 Director 7/15/1938 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Tx Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Union Ave. 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify Completed by 3 Widowed 4 Divorced er than "natur , the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) registered\_nurse health care or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jonathan Dumham Longfellow Wanda Richardson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any injury or other trau K. Bruce Marteny/husband 200 Union Ave., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 3/6/08 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home, Professional Association Signature of Funeral Service Licensee Champano CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a certificate has been signed irector, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an was ...
autopsy
performed?

yes 2 No death? 1∐ Yes 2□ No director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 TYes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🗔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title HOUS9368 MISICIAN. 2180 4 John Paul Visisti

DHMH 17 Rev 1/2001

State

Registrar

30. Name eparadoress of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Restrar's Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>2008 March 4, **Physician** 8:30 PM Gonzalo Martin Martinez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Casey House Montgomery Hospice Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 3 M 2 □ F 43 579-94-5920 May 11, 1964 Washington, D.C Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Montgomery Director Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20874 United States 13215 Dairymaid Drive, #303 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 2 Yes 2 No 1982 — If Yes, Give Year or Dates: 1985 1 Never Married 2 Married Specify: Cuban 1X Yes 2□ No Specify: þ 3 ☐ Widowed 4 X Divorced White 1985 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Plant Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Carmen Martinez Benitez Martin Martinez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M, Cristina Martinez (Sister) 242 E. 19th Street, Apt. 2A, New York, NY 10003 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Metropolitan March 7, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 2008 Crematory 21. Signature of Funeral Semice Licer 22. Name and Address of Facility DeVol Funeral Home, 2222 Wisconsin Avenue, N.W., Washington, DC 20007 23a. Parti. Enter the c sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock or learn failure. List only one cause on each line.

Immediate cause (Final Metastatic Cancer of Unknown Primary Site Approximate Interval Between Onset and Death Metastatic Cancer of Unknown Primary Site **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law page 2 s autopsy performe certificate 1□ Yes 2 X No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:  $_{4\square \, \text{Nursing Home}}$  5  $\square \, \text{Residence}$  6  $\square \, \text{Other} \, \textit{(Specify)}$  Hospice 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No 1 Inpatient P this funeral 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: After (Month, Day Year) or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D64615 March 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D., 1355 Piccard Dr., Suite 100, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 0

Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

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			1 - For State Registrar		,		tificate of		vicinal riyş	Reg. No.	UÜ	0934	
t			1. Decedent's Name (First, Middle, Last)						2. Date of Dea	nath Davi Value			
4	Physici /Medic		Lawrence	Ray	Net	her	S		March	14, 200	8	9:44 a. M	
	Examin		4a. Facility Name (If not institution, give st	reet and number)			4b <del>.</del> City, Town, o	or Location of Death	1	4c. County	of Death		
			1210 Hinton Drive					tingtown		Calvert			
nije.	Funeral Director		229-00-0122	M 2□F 7. Ag	e (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Nov. 30	h, Year) 0, 1948	Cour	place (State or Foreigr ntry) rginia	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation				1	Od. Inside City Limits	
	Maryl f sho	lor	MD Calve	ort		H11	ntingtow	n				1 ∐ Yes 2 <b>XX</b> No	
	the notif	Director	10e. Street and Number	) I U			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	Manuth Ma Manuth Manuth Manuth Manuth	O E	1210 Hinton Drive	9				20639			U.S.	Α.	
	deat	Funeral	11. Marital Status	2. Was Decedent I Armed Forces?	Ever in U.S.	13. \	Vas Decedent of H	Hispanic Origin? (S ean, Mexican, Puerl	pecify Yes or No-	14. Ra	ce - Americ		
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hylgiene. Department of Heatih and Mental Hylgiene. Instrual", or items 23a or 28a-f show amy injuriorant; if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give A Year or Dates:	No		Yes 2MNo		o nican, etc.)	Specil	ck, White, y: W	hite	
2	72 ho natur fical i	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	16	a. Deced	ent's Usual Occup	pation during most of wor	kina	16b. Kind of B	usiness/In	dustry	
2	ithin an "	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	OO NOT use retire	during most of wor ed)	9				
2	led w lygier ner th	S	12			car	penter /	contract				ction	
and	be fi	Be	17. Father's Name (First, Middle, Last)	. 1					ne (First, Middle,		,		
چّ	d Mer narke	은	Ray Brown No.	ethers	140	h Mailia	a Address (Circal	Mary t and Number or Ru	Louise	Dods			
Baltimore, Maryland 21	d2sl than 7isr traur	1 9	Ginger A. Nethers	,				r., Hunti			, siale, zip 639	Code)	
á,	1 and Health Iem 27 other to	5 2	20a. Method of Disposition	, wile	20b. Place	of Dispo	sition (Name of	,	Date	20c. Location		own, State	
ᅙ	Pages nent of int; If Its iry or o		1 Burial 2 Cremation 3 Re	moval from State	1		natory or other pla		8/08	Owings	a MD		
	nit. F artme ortan injur		4 Donation 5 Other (Specify) Mt. Harmony Cemetery 03/18/08 Owings, MD  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A.										
ñ	permit. Departr Importa any info		Baya 1	Teelo	ach	- 1		Harmony I				736	
	Physician /Medical Examiner		23a. Part1. Enter the lise se, or complic shock, or heart failur. List only one Immediate Cause (Findisease or condition resulting in death)	CORON	ne.	AR	ŕ	ng, such as cardiad		rest,		Approximate Interval Between Onset and Death	
68/60,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical Examiner											
P.O. Box 6	at the death certifica by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deal		Ectopic pregnanc	у			ate of delive	ery Day Year	
	res that signed b be deta		Part II. Other significant conditions cont	ributing to death be	ut not resulting	in the ur	derlying cause giv	ven in Part I.	23e. Did to	obacco use con	tribute to t	he cause of death?	
<u>S</u>	quires n sign	q p	HYPERLIPIDE	41A					1 🗆 1	∕es 2□No	3 ☐ Prob	bably 4 Unknowr	
Vital Records,	The ate h	Completed by							24a. Was autop perfo 1 Yes		Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of	
VII	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			O#1		ath (Check only o	ne)			
0	Phy this	7	Yes 2 No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/C	outpatien  Time of	· OLI DOA	her: 4 \sum Nursing F	lome 5X Resid	dence 6 Ot		fy)	
_	e fei	ion	1 Natural 5 ☐ Pending	(Month, Day	Year)	Injury	Wo	rk? ]Yes 2 □ No	200. Describe i	low sijury occu	ii eu		
DIVISION	I or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office City or Town, State)									al Route Number,	
	To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: Al completely filled in by the fur	Medical C	29a. Certifier 1 Certifying Physi (Check only one) 1 Medical Examin		examination a								
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)	
)			Ptter fl	M		\/T	D40	370		3/1	7/08	3	
			30. Name and address of person who cor Peter L. Wisniews		` '			, # 310.	Prince 1	Frederi	ck, M	D 20678	

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 2 1 2008

**ORIGINAL** 

Been It

	State of Maryland / Dep		Mental Hygien	е							
	1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. N	o. 2008 035							
Physician /Medical	Joseph J. Oleinik			ay Year 7:59 PM							
Examiner	4a. Facility Name (If not institution, give street and number)  Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	4	c. County of Death Washington							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign							
Director	578-28-4049 1™ 2□F 80 Yrs.	Months Days Hours Min.	(Month, Day, Yea Aug. 7, 19	927 Washington, DC							
×	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits							
f sho led at		liamsport		1							
r 28a- notif	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?							
23a o Ist be	15445 Dellinger Road	21795		USA							
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ ▼Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married I ↑ ▼ Married Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?  16. Was Decedent Ever in U.S. Armed Forces?  17. Was Decedent Ever in U.S. Armed Forces?  18. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  10. Was Decedent Ever in U.S. Armed Forces?  10. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert     □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  SpecifyWhite							
ygiene. her than "natural t, the Medical Ex Completed k	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	eedent's Usual Occupation we kind of work done during most of wor . DO NOT use retired)	king 16b.	 Kind of Business/Industry							
giene ar than the N	Elementary/Secondary (0-12) College (1-4or 5+)	Salesman	1	Home Improvement							
d othe event, Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	en Surname)							
Meniarked	Joseph C. Oleinik		Flournoy								
eaith and m 27 is m ner traum	James C. Oleinik/Son 1544	iling Address (Street and Number or Ru 5 Dellinger Road,	Williamspor	et, MD 21795							
nent of H ant: If iter ury or oth	1 Surial 2 □ Cremation 3 □ Removal from State		cn 15,	Location - City or Town, State Silver Spring, Maryl							
Departr Imports any inju	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collin 500 University B1									
ysician Medical	23a. Part1. Erner the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death Welle							
aminer	Due to (or as a consequence of):  b. Due to (or as a consequence of):  b. Due to (or as a consequence of):	his Intertwiel Blue COLITIS	ding	1 week							
physician and the burial-transit dical Examiner	resulting in death) Last Due to (or as a consequence of):										
attending for use as		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year							
be q	1 - Voe 2 - No 2 -										
r this certificate has been s ral director, page 2 should TO Be Completed:			24a. Was an autopsy performed? 1∐ Yes 2 2 11								
ector,	25. Was case referred to medical examiner?	Othor	th (Check only one)								
After this funeral dir	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Cutpati  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how in								
To the Funeral Director: After the completely filled in by the funeral Medical Certification: T	2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)							
or the Funeral ompletely fille	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)							
To ti	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)							
+1	I Vlede mo	1 146561	0	3.08.2008							
, ,	30. Name and address of person who completed cause of death (Item 23a) (Type G   HT	. 0.0 110,100	STOUN, MI)	21740.							
State Registrar	31. Date filed (Month, Day, Year)  MAR 1 0 2008	nault a									

DHMH 17 Rev 1/2001

GWIII FIAIIIOIG F		State of Maryland / Department of Health and Mental H	-	eg. No.	200	8 0935				
Physici	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea	ith Day	Year	3. Time of Death				
Medical Exami		Edwin Hanford Preston  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	March 3,	2008	ounty of Death	1509 hrs				
		Southbound I-95 Columbia		How						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_	rth (MM/DD/		thplace (State or Foreign untry)				
Director		220-78-5314 1x M 2 F 35 Yrs. Months Days Hours Min		31, 197		rict of Columbi				
any	H	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	-			10d. Inside City Limits				
ě "	٦	D.C. Washington				1 X Yes 2 No				
Maryland 28a-f show datonce	Director	10e. Street and Number 10f. Zip Code		10g. Citizen	of What Coul	ntry?				
ith the Maryland 23a or 28a-f sho notified at once.		3642 13th Street, NW 20010			U.S.A					
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sht the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	0-   14.	. Race - Ameri White, etc.	ican Indian, Black,					
fter de l'', or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify:	Spe	ecify:	Black					
136 hin 72 hours at te. than "natural edical Examin	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind	of Business/	Industry				
36 iin 72 l fran "-	plet	Elementary/Secondary (0-12) College (1-4 or 5+)  5+ Surgeon	geon Medical							
15-00 filed with Hygiene d other (	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maiden Sur						
21215-0036 should be filed within 72 hours afte and Mental Hygiene, is marked other than "natural", aric event, the Medical Examiner	Be		zabeth H		·					
md 2 should and 2 should ealth and M I should lem 27 is m Irraumatic erraumatic	٩	19a. Informant's Name/Relationship (Type, Print )  Mamie Mesfin-Preston - Wife 19b. Mailing Address (Street and Number or 3642 13th Street, NW, Walter 19b. Mailing Address (Street and Number or 19b		•		e, Zip Code)				
imore, MD 2 Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Loc	ation - City or	Town, State				
MOF Pages   ent of   nt: If		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Parklawn Memorial Park 03/11/2008 Rockville,								
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		21. Signature of Funeral Service Licensee 22. Name and Address of Facility ines-Rinaldi Funeral Home, Inc.								
		23a. Part I. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac	enue, Silv	ver Spr	ring, Maj	vland 20904 Approximate Interval				
/Medical	/Medical failure. List only one cause on each line.									
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple injuries  Due to (or as a consequence of):								
	16	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				-				
1	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.								
d ansit	Exa	events resulting in death) Last Due to (or as a consequence of):  d.								
760, icate be executed thysician and the burial - transit	Medical	UNPENDED AMENDED								
760 ficate b g physic the bui	/Me	IF FEMALE:  23c. If yes, outcome of pregnancy  1  Live birth  25c. If yes, outcome of pregnancy	annow.		Date of deliver	y Day Year				
Box 687 death certificathe attending ped for use as th	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	iancy	NA.	Ontri	Day You				
BO he deat the at hed for	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	230 Did	tobacco use	e contribute to	the cause of death?				
P.O. es that the	ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				bably 4 Unknown				
ds, require	Completed		24a. Wa			utopsy findings available completion of cause of				
ecor ne law te has l	I d m	autopsy performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No								
al R		(Check only one)								
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	examiner? 1 Very 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other: Scene 27. Manner of Death  28a. Date of Injury  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred									
nding J h. Afte e funer		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, 2008)  28b. Time of Injury 1500 hrs  28c. Injury at Work?  1 Yes 2 ✓ No	Subject dri			ved in vehicular				
risio r Atter ter dear irector n by th	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	accident 28f. Location	(Street and	Number or R	ural Route Number, City				
Div pital o ours afi eral D	Certification:	4 Homicide determined (Specify) Interstate/Express	or Town, Southbound	I-95 , Colu	umbia , MD					
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the car	use(s) and r	manner as sta	ted. he cause(s)				
To the within to the comp	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number				onth, Day,Year)				
IV	-	o.c.m.e. OCM	E	March	1 4, 2008					
<b>—</b> '		30. Name and address of person who comple ed have of death (Item 23a)								
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	re, MD 2120	)1						
S Regis	tate trar	31. Date filed (Mann) Pay Year) 2008 32 Registrar's Signature								

		1 - State Registrar			,	C	ertificate	of	Death		Reg.	No. 2	1118	0	935
Physic		1. Decedent's Name (First, Midd Boris Vladimi			dobedo					2. Date o Month	Death	Day 27,	Year 2008		e of Death
/Med Exam		4a. Facility Name (If not institution				<u> </u>	4b. City, T	own, o	r Location of De			4c. County		т.	JU I
LAGIN	IIICI	17400 Amity Dr	ive		,			Gai	thersbu	rg		Мо	ntgom	erv	
Funera		5. Social Security Number None	6. Sex	M 2□F	7. Age (In y	rs. last birthda 97 Yrs.	y) If Under 1		If Under 24 F	frs. 8. Date o	0 5			lace (Stai	te or Foreig
Directo	4	Usual Residence of Decedent				97				July	19,	1910	UKra	Ine	
land ow		10a. State 10b. Count	/		10c.	City, Town or	Location						1	0d. Inside	e City Limits
Many -fsh	ģ	Russia Mosco	w Re	gion	T	roitsk								1 □Y	res 2⊠No
r 28a	Director	10e. Street and Number					10f. Zip (	Code			10g.	10g. Citizen of What Country?			
h witi 3a o st be	a D	30 Centralnaya	Str	eet,	#171			N/L	A		Russia				
death	Funeral	11. Marital Status	1		cedent Ever in	1 U.S. 13	B. Was Decede			(Specify Yes o		14. Rac	ce - Americ		1,
after or ite	I	1 ☐ Never Married 2 ☐ Ma	rried	Armed F	2 🔀 No			Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical  1 ☐ Yes 2 ☐ No Specify:			1		ck, White,		
ral", c	by	3 ☑ Widowed 4 ☐ Divorce	t	If Yes, G Year or D	Dates:		TLI Yes 2	r <b>X</b> I40	Specify:			Specif	v: Wn	ite	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed	15. Decede (Specify only high	nt's Educ	cation e completed	)	16a. Dec	workina	16b	. Kind of B	usiness/Ind	dustry				
ithin ser ser ser ser ser ser ser ser ser ser	lg.	Elementary/Secondary (0-12)	Ĭ	College (	(Give kind of work don life. DO NOT use retir										
ed w ygier t, the	S	<del>-</del>		5-	<del> </del>	Cons	tructi	on ]	Enginee				<u>uctio</u>	<u>n</u>	
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle					18. Mother's Name (First, Middle, Maiden Surname)						ne)		
Men Men arke	ဥ		obed			Polina Sokolova									
2 sh and is m		19a. Informant's Name/Relation Vyacheslav B.		,	(Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 17400 Amity Drive, Gaithersburg, Maryl								77
and lealth m 27			Todo	Dedov											
Pages 1 nent of F int: If ite		20a. Method of Disposition 1 Burial 2 Cremation	3 □R	emoval from	State	o. Place of Dis cemetery, ci	position (Nami rematory or oti politar	e or her plac	ce) Ma	Date arch 1,			- City or To		
tmen tant:		4 □ Donation 5 □ Other (	Specify)			Crei	natory			2008			lria,	Virg	ginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any name.		21. Signature of Funeral Service	License	ee			22. Name and			DeVo1				_	
		11-1	The							Drive,		nersb	urg,	MD 2	
Physician		23a. Part1. Enter the disease, on shock, or heart failure. List Immediate Cause (Final diseases of carditions)	r compli it only or	ne cause on	caused the di each line.		nter the mode	of dyir	ng, such as care	diac or respirato	ry arrest,			Approxir Interval I Onset a	mate Between ind Death
/Medica		disease or condition resulting in death)	a a		(or as a cons								$-\Gamma$	) 0	0 ~
Examine				Fra	cture	Hip							_	- 41	15
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to	(or as a cons	sequence of):									
cutec nd ransî	Examiner	that initiated events	1.												
exe an ar rrial-t															
icate be executed physician and sthe burial-transit	ca		C d		-										
a go	Medical	IF FEMALE:									-				
eath ce attendii		23b. Was decedent pregnant	2		itcome pf pre- birth 2 ☐ F		B⊟Ectopic pre	anancy	,			į.	ate of delive	-	
ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at time of		☐ Other (spe		,	<del>.</del>		Mo	onth	Day	Year
res that the de signed by the a	Physician/	9 Unknown													
es the igned	by	Part II. Other significant condit	ions cor	itributing to d	leath but not i	resulting in the	underlying ca	use giv	en in Part I.				tribute to th		
w require been si should b										-   -	☐ Yes	2 <b>X</b> No	3∐ Prob	ably 4	Unknow
e law r has be	Completed										las an utopsy	24b.	Were auto	psy findin	ngs available of cause of
	Ş										erformed	?	death?	2 No	
ding Physician: The In. After this certificate he funeral director, page	Be (	25. Was case referred to medic examiner?	al						26. Place of I	Death (Check o				Con	
hysic his ce	101	1 X Yes 2 No	H		-	ER/Outpati	ent 3 DOA	Oth	er: 4 ☐ Nursin	g Home 5 □ F	Residence	e 6 <b>X</b> ∃Oth	ner <i>(Specif</i>	Son Res	idenc
ng P fter t	=	27. Manner of Death 1 □ Natural 5 □ Pendi	na	28a. Date (Mor	of Injury oth, Day Year	28b. Time Injury	of 28	c. Injur Wor		28d. Descr	be how in	njury occur	red fel	1 ge	tting
earth.	Satio	2 X Accident invest	igation		31,200		P M		Yes 2X No	out c	f ch	air i	n kit	chen	1
r Att	ertification:		nined	28e. Place build	e.of injury - A ling, etc. <i>(Sp</i> e	t home, farm, s ec <i>ify)</i>		office		28f. Location	n (Street Town, St	tand Numb tate) 17	er or Rura	I Route A	Vumber,
ital c ral D	ē						ome			Gaith	ersb	urg,	MD ZU	08//5	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 ☐ Certifyi (Check only one) 2 ☑ Medica	ng Phys I Examii	ner: On the I	e best of my l basis of exam oner stated.	knowledge, de nination and/or	ath occurred a investigation,	t the tir in my c	me, date and pl opinion, death o	ace, and due to occurred at the ti	the cause me, date	e(s) and mand place,	anner as si and due to	tated. the caus	se(s)
To th To th comp	Me	29b. eignature and title of certifi	7		1		29c.	Licens	e number		29d.	Date signe	ed (Month,	Day, Yea	(r)
/		mont D00428 Feb. 28,2008													

State Registrar

Dr. Ira N. Brecher M.D. DME 2101 Medical Park Dr. . Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 1 0 2008

Silver Spring, MD 20902

			1 - For State Registrar	State of Ma	aryland		artment of H Stificate of I		, ,	giene Reg. No		0000
	Physici	an	1. Decedent's Name (First, Middle DOROTHY C.	, Last) ROBBINS					2. Date of Dea	ath	y8 200'8	3. Time of Death 5:00 am
	/Medic	cal	4a. Facility Name (If not institution				4b. City, Town, or	r Location of Death			County of Death	3:00 am
	_ Xuiiiii		Chester Rive	-			Cheste	_			Cent	
ŀ	Funeral Director		5. Social Security Number 217-44-0835	6. Sex 7. Ag	e (In yrs. Ias 59	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 1	h v, Ye <i>ar)</i> 2 1	9. Birthp Cour 948 Mai	place (State or Foreign cyland
	/land low at		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation				1	0d. Inside City Limits
	e Mar 3a-f sh tified	ctor	MD Kent		Gale	ena						1 XXYes 2 □ No
	with th	Dire	10e. Street and Number 107 W. Cros	a st Ant	8-H		10f. Zip Code 21635				izen of What Cour	ntry?
	death ims 23 r musi	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of H		pecity Yes or No-		14. Race - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ام ا	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced		No		Tes, specify Cuba	Specify:	Hican, etc.)		Black, White, Specify: Wh	etc. iite
15-0	n 72 ho "natu edical	Completed	15. Decedent (Specify only highes			16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of work	king	16b. K	ind of Business/In	dustry
212	d withingjiene.	omo	Elementary/Secondary (0-12) 1 2	College (1-4or l			itality			Pr	ivate C	ollege
pu	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, James E. Con					18. Mother's Nam			,	
ryla	hould id Men marke matic	우	19a. Informant's Name/Relationsh			19b Mailir	g Address (Street		d Ann I			Code)
Ma	alth ar 27 is er trau		Stephanie Edv		111							,
ore,	ges 1 are to f He If item		20a. Method of Disposition  1 Burial 2 Cremation		20b. Plac	ce of Dispo	sition (Name of natory or other place	ce)	Date		ocation - City or To	
altimore,	it. Pagintment		4 □ Donation 5 □ Other (Si	pecify)	Ken		emation  Name and Address		2/08	Sm	yrna, D	Е.
Ba	Depa Impo any l		A		M0051	_   G	alena F 18 West	uneral	Home of	f S	tephen	L. Schaed 21635
Ī.			23a. Parti. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	i the death. ne.	Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	a g MD .	Approximate Interval Between
	Physician /Medical		Immediate Caus (Final disease or condition resulting in death)				LDIAC 1	NFARC	MON			Onset and Death
	Examiner			Due to (or as		,	PIERY	DISEA	SE			> 5 years
	P ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequer	nce of):						,
	xecute and Il-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequer	nce of):						
58760,	icate be executed physician and s the burial-transit	dical E		d								
x 68	ertifica ing ph e as th		IF FEMALE:									
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ery Day Year
ď.	s that t ned by e detac	by Ph	Part II. Other significant condition	-				en in Part I.	23e. Did to	bacco i	use contribute to the	he cause of death?
ord	require sen sig ould b	ted k	LUMBAR D	ISK SPAC	EIN	JFE	CHON		1 🗆 Y	es 2	□ No 3 Prot	pably 4 □Unknown
Rec	The law ate has b page 2 st	Completed					·		24a. Was a autop perfor 1□ Yes	sy	prior to co	psy findings available impletion of cause of 2 No
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Deat				·
0	g Physer this	n: 70	1 ☐ Yes 200 No 27. Manner of Death	28a. Date of Inju	ent 2 EF	8b. Time of	, JUDOA	4 LI Nursing He	ome 5 Resid		6 □Other (Specit ry occurred	(y)
Sion	eath. or: Aff	atio	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation		Injury	M 1 🗆	Yes 2□No				
DIX	ital or Att rs after de ral Direct led in by t	Certification:	4 ☐ Homicide determi	ned 28e. Place of Inj building, et	c. (Specify)		eet, factory, office		City or Tow	n, State		
	To the Hospital or Attending Physician: The lwithin 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	(Check only 2 Medical I	g Physician: To the best Examiner: On the basis o and manner st	f examination	edge, death n and/or in	estigation, in my o	pinion, death occu	, and due to the or rred at the time,	date and	) and manner as s d place, and due t	tated. o the cause(s)
)	To with	2	29b. Signature and title of certifier	of Noble	- nv.	D	29c. Licenso	004158		29d. Da	te signed (Month,	Day, Year)
			30. Name and address of person Melen A	who completed cause of d				Ch 1			24.55	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	e	peer Rd	<u> cheste</u>	ercown,	ML	21620	J
DU	Registr		MAR 2 4 201	18 Beach	As A	Second .	1					
DΗ	MH 17 Rev 1/2	UUT			- 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 4a State of Maryland / Department of Health and Mental Hygiene WCHD/SH 3/13/08 per Dr. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1604 PM 2008 Mitchell Aaron Rose 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1522 Dual Highway Washington County Hosp 5. Social Security Number 6. Sex Hagerstown
If Under 1 Year | If Under 24 Hrs. Washington County 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Hours Director 218-58-7148 August29.1952 55 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10c, City, Town or Location 10b. County 10d, Inside City Limits 1 ☐Yes 2X No Directo Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1522 Dual Highway 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give 1969 1987 Year or Dates: 1987 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Kyle Rose Eleanore H. Mullins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mitzi Lee Rose-wife 1522 Dual Highway Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buria! 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial Park 3-15-2008 Hagerstown, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alhero Scherotic Covaliavasculav disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner extorsily Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last liabertes attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 10 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 No Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 🔀 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03-11-2008 DS 2323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH9+1 Khalid Waseem 1126 Opal Ct., Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 1 2 2008

**ORIGINAL** 

			1 _ State	of Marylan	-	rtment of F		Mental Hy	/giene Reg. No.	2008	09355
			Registrar  1. Decedent's Name (First, Middle, Last)			imodio or i	50417	2. Date of D	eath		3. Time of Death
	Physici /Medio		Caroline DiPietro	Riggi	0			March			0210 M
	Examir	er	4a. Facility Name (If not institution, give street and	number)	nlev	4b. City, Town, o	r Location of Dea	th	4c. C	County of Death  William i	(A)
	Funeral		5. Social Security Number   6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth av. Year)		lace (State or Foreign try)
j.	Director		113-01-7702 1 □ M 2 🖫 F Usual Residence of Decedent	87	Yrs.	Monars Days	/ rouns   Will	12/17/		Mass	sachusetts
	yland now at		10a. State 10b. County	10c. City	, Town or Loc	cation				11	0d. Inside City Limits
	e Mar Sa-f sh tified	Director	Maryland Wicomico		Salisbu	ury					1 □Yes 2 No
	a or 2	Dire	10e. Street and Number 604 Tony Tank Lane			10f. Zip Code 2180]	1		-	en of What Coun JSA	try?
	death ms 23	Funeral	11 Marital Status 12. Was D	ecedent Ever in U.	S. 13. V	Vas Decedent of H		Specify Yes or N		4. Race - America	
030	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes,	Forces? s 2 No Give r Dates:		Yes 21X No	an, mexican, Pue	no Hican, etc.)		Black, White, of Specify: whi	
2-0036	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	16a. Deced (Give )	ent's Usual Occup kind of work done OO NOT use retired	ation during most of we	orking	16b. Kin	d of Business/Inc	lustry
Z	within lene. than the Me	duic	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)		naker	a)		do	mestic	
anaz	e filed al Hygi other vent, t	Be Co	17. Father's Name (First, Middle, Last)					me (First, Middle	e, Maiden S	Surname)	
yıar	Menta Menta arked	To E	Guiseppe DiPietro					Sessa			
, mar	and 2 sh ealth and n 27 is m	2000	19a. Informant's Name/Relationship (Type. Print) Carole ann Bernstein/c		604	g Address (Street tony Tar	and Number or F nk Lane,	Salisbu	ry, M	1D 21801	
saltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal fro  4 □ Donation 5 □ Other (Specify)	om State Cro	lace of Dispos emetery, crem DWNSVII emetery	sition (Name of natory or other plac .le Veter 7	ans 3/	Date L1/08		ation - City or To wnsville	
pali	permit. Departimport any Inj		21. Signature of Funeral Service Licensee	~			Funeral Hill Rd	Home Pr	ofess bury,	sional As MD 2180	ssociation 04
			23 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	t caus d the death n each line.	n. Do not ente	er the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Ì	Physician /Medical		resulting in death)	EVERE =							Olbot and Boat.
	Examiner		4	to (or as a consequ NEUMON							
	D to	iner	if any, leading to immediate Due cause. Enter Underlying	to (or as a consequ	uence of):	1					
F.	xecute and al-trans	Examiner	that initiated events resulting in death) Last  C  Due	to (or as a consequ		MENTIA					
2/00	icate be executed physician and the burial-transit	dical E	d								<u></u>
200	ertificating physical seas the	Medi	IF FEMALE:								
X D D	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	outcome pf pregna re birth 2□Feta egnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	у		23	3d. Date of delive Month	ry Day Year
5	t the d sy the ached	hysi	1 □ Yes 2 Da No 9 □ Unknown 9 □ Ur	known	Juli 5_						
,	es tha igned I	by P	Part II. Other significant conditions contributing to	death but not resu	ulting in the un	derlying cause giv	ren in Part I.				e cause of death?
ecords,	requii	eted								No 3 Prob	
ŭ	The law ate has b	Completed						24a. Was auto perl		prior to cor death?	psy findings available mpletion of cause of
	lan: T	a)	25. Was case referred to medical				26. Place of De	1  Yes eath (Check only		1 ☐ Yes	2 No
> 5	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1	∑ Inpatient 2 □	ER/Outpatient		er: 4 ☐ Nursing	Home 5□Res	idence 6	□Other (Specify	/)
	Jing P After t funera		1 XNatural 5 ☐ Pending (ħ	ite of Injury fonth, Day Year)	28b. Time of Injury	Wor	ryat rk? Yes 2 ∐ No	28d. Describe	how injury	occurred	
VISION	To the Hospital or Attending Physician: The law within 24 the rours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	27. Manner of Death 1 X Natural 28a. Date of Injury 28b. 1 Ime of Injury at Work? 2 Accident 3 Suicide 4 Homicide 28b. Place of injury - At home, farm, street, factory, office 28b. Place of injury - At home, farm, street, factory, office 28b. 1 Ime of Injury at Work? 1 Yes 2 No 28b. 1 Ime of Injury at Work? 2 North North, Day Year) 28b. 1 Ime of Injury at Work? 2 North North, Day Year) 28b. 1 Ime of Injury at Work? 2 North North, Day Year) 28c. Injury at Work? 3 North N									I Route Number,
5	oital or urs aft eral Di										
	e Hos 24 ho e Fun letely	edical	29a. Certifier 1 💢 CertifyIng Physician: To (Check only one) 2 Medical Examiner: On the and m	e basis of examina anner stated.	tion and/or inv	estigation, in my	opinion, death oo	ce, and due to the curred at the time	e, date and	place, and due to	the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	IMD		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
,	( )		V. Durpour			200	63991		3	-7-200	3(
	UGN		30. Name and address of person who completed of	ause of death (Item	23a) (Type, F	Print)	S 4.		11.	2/6	
8.	Sta	ite	31. Date filed (Month, Day, Year)	ause of death (Item	ture	HERCIL	n. JA	usbury	MI)	2180	
	Regist	ar	MAR 1 0 2008	Alca.	15 A						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

**Physician** /Medical Examiner

> ral", or Items 23a or 28a-f show Examiner must be notifled at "natural", or

filed within 72 hours after death with the Maryland other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event **Physician** /Medical

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760. attending physician the the To the Hospital or Attending Physician:

within 24 hours a To the Funeral I

1. Decedent's Name (First, Middle, Last) Day Month Year Theodore Bernard Solomon 2008 1:15 A.M March 6, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1**⊠** M 2□ F Months Days Hours Min **Director** 087-24-2668 76 Oct. 22, 1931 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland | Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20005 Hoffstead Lane Funeral 20886 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 □ No 1949—
If Yes, Give
Year or Dates: 1952 1 Never Married 2K Married 1 ☐ Yes 2X No ģ Specify 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Manager Airlines 17, Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Solomon Augusta Gunty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Solomon/Wife 20005 Hoffstead Lane, Montgomery Village, MD. 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 3/7/2008 | Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardioc enic 30545 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death Month Dav Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 dnknown Completed 24b. Were autopsy findings availeble prior to completion of cause of death?

1 ☐ Yes ➤ No 24a. Was an tailure 306 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 medical Cestar Drive, Rodevine, MD 20850 440 Z egistrar's Signature 31. Date filed (Month, Day, Year) MAR 1 0 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ам 02, Luiza 2008 5:57 Maria Sault March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 102 Wall Street Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex Days 1 ☐ M 2 🔀 F 227-42-0936 72 March 3, 1935 Romania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 100 Duvall Lane #303 20877 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No 2 Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Kar1 Siniawski Schrier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Sault / Son 102 Wall Street, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory 3/7/2008 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enverthe dis + m, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of h art fail e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca — (Final disease or condition resulting in death) Metastatic urinary bladder cancer 6 months Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Coronary artery disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify/Son's home 1 | Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Examiner burial-transit and Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial Certification: To

**Funeral** 

Director

show

7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

72 hours after

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2.
Department of Health ar Important: If Item 27 Is nany Injury or control of the Item 27 Is nany I

Physician

/Medical

3altimore, Maryland 21215-0036

1 X Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

25.	Was case examiner?	referred	to medical
	1 ☐ Yes	2⊠ No	
27.	Manner of	Death	

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cert

MAR 10

29c. License number D28656 29d. Date signed (Month, Day, Year) March 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

15225 Shady Grove Road #208, Rockville, MD 20850 Ravi Passi, M.D.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 OY **Physician** SHROPSHIRE 0700 M 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER
Age (In yrs. last birthday) UNDE Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number **Funeral** 3 Yrs. 1□M 32 F Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show item 27 is marked other than "naturel", or items 23a or 28a-f sho other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ™Widowed 4 □ Divorced NITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental ! -IDDIE MOWERY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 MD-Z1122 Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Depertment of important: If eny injury or soce. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death 22a. Part. Efter the diseas shock, or heart failure. nplications that bassed the death.

y one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arres Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ( Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ettending physicien end for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) pege 2 should be detached 9 ☐ Unknowń 23e. Did tohacco use contribute to the cause of death? Be Completed by Medical Certification: To

or Attending Physician: The faw requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director,

C.	PD		ing cause gi	on an rant.	1 Pes	2 No 3 Probably 4 Unknown
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical				26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 253 No	Hospital:	2 ER/Outpatient 3	DOA Ot	ner: 4 🗆 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day )	(ear) 28b. Time of Injury M	28c. Inju Wo 1 [		28d. Describe how in	ury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		- At home, farm, street, fa (Specify)	ictory, office		28f. Location (Street: City or Town, Sta	and Number or Aural Aoute Number, te)
	Physician: To the best of examiner: On the basis of examiner and manner state	camination and/or investig				(s) and manner as stated. nd place, and due to the cause(s)
			20e Licens	a number	±104 F	late cirened (Month Day Veer)

EFENSE

State Registrar

LHARL 31. Date filed (Month, Day, Year)

Name and address of person

32. Registrar's Signature

w



DL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary			of Health a of Death	and Me		iene) eg. No.	08	09359
			Decedent's Name (First, Middle, Last)					:	2. Date of Deal	th Day	Year	3. Time of Death
	Physici /Medic		Andrew G	. Sliger					March	16 2	2008	1 .57 PM
	Examin		4a. Facility Name (If not institution, give	street and number)			wn, or Location o				y of Death	
			813 Sherrill				esvill				ford	
	Funeral Director		5. Social Security Number 6. Security Number 183–18–8291	_	yrs. last birthday 33 Yrs.	Months D	ear If Under a	Min.	<ol> <li>Date of Birth (Month, Day)</li> <li>01 – 23 –</li> </ol>	, Year)	Cour	place (State or Foreign ntry) sylvania
	D .		Usual Residence of Decedent	100	c. City, Town or L	ocation					1	10d. Inside City Limits
	anyla ehov	<u>_</u>										1 ☐ Yes 21 No
	88a-1	ecto	Maryland Har	ford	Pylesv	111e 10f. Zip Co			1	0g. Citizen of	What Cour	ntry?
	with t	古								U.S.		
	s 23	era	813 Sherrill Dr	1VE 12. Was Decedent Ever	in U.S. 13.		132 t of Hispanic Orie	gin? (Spec	cify Yes or No-		ce - Americ	
36	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow the Medical Exeminar must be multiled at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩		If Yes, specify 1 ☐ Yes 2 ☐	t of Hispanic Original Cuban, Mexican Moscify:		lican, etc.)	1	ack, White, ify: Whi	_
Ş	hour tural		15. Decedent's Edu		16a Dece	dent's Usual C	Occupation			16b. Kind of E	Business/In	dustry
5	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work of DO NOT use r	do <i>ne duri</i> na mosi	t of workin	g			
72	the in	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Coi	ırier				Banki	ng	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Hailih and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Marcical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last) Russell J. Sliger						(First, Middle, Shenbe		me)	
<u> </u>	should and Men amarke umaric	၉	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ing Address (S	treet and Numbe	er or Rural	Route Number	r, City or Town	n, State, Zip	Code)
S	of Health and I lem 27 is		Gertrude F. Sliger	/Wife	813	Sherril	l Drive	, Pyl	esville	e, MD	21132	
Baltimore,	Hear Hear Hear Othe	100	20a. Method of Disposition	2	Ob. Place of Disp					20c. Location	- City or To	own, State
5	ages ent of nt: If I		1 ☐ Paurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Slate Ric			/19/2	:008 I	elta,	PA	
≣	permit. Pages Department of H Important: If Its any injury or of		21. Signature of Funeral Service Licens	ee /	2 - 2	2. Name and A	Address of Facilit	ty	6	00 Ma	in S	t.
ä	Departi Departi Import any inj		& lakling R	Too le	Ve I	larkin.	s Fune:	ral	Home r	elta,	Da.	17314
	Dhusisian	1	23a / an1. Enter he dise use, or comp shock, or heart failure. List only Immediate Cause (Final	icati s that caused the ne use on each line.	deat) Do not er	nter the mode o	of dying, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a co	insequence of):	ing c	unce		)			Q MILL
	Examiner											
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence of):							
	be executed ician and burial-translt	Examiner	Cause (Disease or injury that initiated events	c								
oʻ	exec an an rial-tr		resulting in death) Last	Due to (or as a co	insequence of):							
760,	e ys	cal		d								
68	tifica ng ph as th	Med	IC COLLE									
Box	The law requires that the death certificate to has been signed by the attanding phy agge 2 should be delached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregi □ Other (speci				_	ate of delived	very Day Year
P.0	that the de led by the a detached	چ	9 🗆 Unknown						on- Dida		atabuta ta	the cause of death?
Vital Records, I	quires than signed and be de	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the	underlying caus	se given in Part I	l. 		es 2 No		bably 4 Unknown
00	w requir s been si should	Completed							24a. Was		. Were aut	opsy findings available ompletion of cause of
Re	The lavate has	E							autop perfor 1 ☐ Yes	med?/	death?	2 □ No
B		Ö	25. Was case referred to medical				26. Place	e of Death	(Check only o			
5	Physiclan: this certific ral director,	ToB	evaminer?	Hospital:	2 ER/Outpatie	ent 3□ DOA	Other: 4 N	ursing Hon	ne 5 Resid	lence 6 🗆 O	ther (Spec	ify)
o	g Phy er this eral c		27. Manner of Death	28a. Date of Injury	28b. Time		. Injury at Work?	2	28d. Describe h	now injury occ	urred	
O	th. : After s funer	i i	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	М	1   Yes 2	No				
Division	ial or Attending is after death.  al Director; After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, s Specify)	treet, factory, o	office	2	28f. Location (5 City or Tox		nber or Ru	ral Route Number,
_	Hospit 4 hour Funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of m inar: On the basis of exa and manner stated	amination and/or	ath occurred at nvestigation, in	the time, date ar my opinion, dea	nd place, a ath occurre	and due to the a	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stated	•		icense number	, ,		29d. Date sign	ned (Month	, Day, Year)
	F 3 F 8		D.	~		D	548	41		3/1	0/0	8
•			30. Name and address of person who o	ompleted cause of death	(Item 23a) (Turn	Print)						
			Su. Name and address of person who d	Can i Gi	14 Dh	lade	2/ place	Rd	54	ite 2	08	Batte. Mda
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4432	· pri ot					
	Regist		MAR 2 4 200	18	As Ago	344						

DHMH 17 Rev 1/2001

ORIG!NAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend Items State of Waryland / Department of Health a Registrar 17 & 18, WCHD/SH 3/19/08 pe Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marit 085 LO A M LILLIAN SUDER 10 HULDAH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 15 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, <sup>Yea</sup>r) 1922 **Funeral** Ohio Days Hours Min 1 □ M 2**X**□ F 219-03-3287 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If then 27 is marked other than "natures" ----- any Injury or other trained. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 X Yes 2 □ No Washington Hagerstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 509 Rhode Island Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify þ X☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Rural Mail Carrier Elementary/Secondary (0-12) College (1-4or 5+) US Post Office 18. Mother's Name (First, Middle, Maiden Surname)
Hazel Blanche Yohe
Hazel Belle 17. Father's Name (First, Middle, Last) Be Şmith Josiah Cramer. <del>Josiah</del> ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 19a. Informant's Name/Relationship (Type. Print) Gary W. Suder Son 509 Rhode Island Avenue, Hagerstown, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Cedar Lawn Memorial Pk, 03-14-08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Scensee Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and D Immediate Cause (Final achiva **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months. 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 9 I Inknown 9 Unknown 1.24 hours after death.

E Funeral Director: After this certificate has been signed by it.

E Funeral Director: After this certificate has been signed by it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 Unknown Completed r24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated within 2. 29d. Date sign 29b. Signature (\_ and addies 8 3H-4 ar's Signature 31. Date filed (Month. Day State

DHMH 17 Rev 1/2001

Registrar

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

しつしつ

00063730

HOSPITAL

ELIKTON

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mai	ryland / l		tment of H ificate of L		nd Mer		iene eg. No. 2	008	09362
	Discontint	ωγ.	1. Decedent's Name (First, Middle, Last	)						Date of Dea Month	th	Year	3. Time of Death
	Physici /Medic		Harry Leonard	Tennant,	Jr.					larch [	Day 2008		10:20 a M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of E	Death		4c. Coun	ty of Deat	h
		24	8507 Glenville Ros 5. Social Security Number 6. Se		(In um loot hi	uth day ()	Takoma I	Park I Under 24	Hrs. 0	Date of Birth	Mor	ı tgon	hplace (State or Foreign
	Funeral Director			x 2□F 7. Age 87	(In yrs. last bii 7		Months Days		Min.	(Month, Day			carray)
	_		Usual Residence of Decedent	0.1					Ivi	lay 14,	1920	wes	st Virginia
	yland how at		10a. State 10b. County		10c. City, Tow	n or Loca	ation						10d. Inside City Limits
	e Martartartified	Director	Maryland Mor	tgomery	Ta	koma	Park						M2 Yes 2 □ No
	ind the or 28	Dire	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	What Co	untry?
	ath w		8507 Glenville F				20912				U:		
	er de itema ner n	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1xxx es 2 □ No		13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin an, Mexican, F	n? (Specify Puerto Rica	/ Yes or No- an, etc.)		ace - Ame ack, White	rican Indian, e, etc.
-0036	ırs aft Il", or xami	by F	Widowed 4 Divorced	If Yes, Give Year or Dates:		1[	∐Yes 2√k No	Specify:			Spec	ify: Wh	ite
Ę.	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		15. Decedent's Edu	cation		. Decede	nt's Usual Occupa	ation		- 1	16b. Kind of	Business/	Industry
2	hin 7 e. an "n Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)		life. DO	nd of work done of NOT use retired	during most of ()	f working				
V	filed within Hygiene. other than "	Con	12			A	uto Mech	nanic			Autor	nobil	e
and	e d d d d	Be	17. Father's Name (First, Middle, Last)								Maiden Surna	ame)	
<u> </u>	12 should be 1 n and Mental I ris marked o' raumatic eve	P	Harry L. Tennant					Abbie					
2	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (7)	,			Address (Street a						Zip Code)
ָם ב	ss 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Larry Tennant/Son 20a. Method of Disposition	1	20b. Place of	f Disposit	Roop Roa	i	<u>v Win</u> Date	1	MD 217 20c. Location		Town, State
2	ages ent of it: If II		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		1	-	oln Ceme	, , , , , ,	arch	10,	_	,	
Daltimo	permit. Pages of Department of Hamportant: If Ite any injury or of Once.		21. Signature of Funeral Service Licens		1010	22. 1	Name and Addres	s of Facility		2008			, Maryland
Ď	permi Depar Impor any ir		James 5	deles.		Fr	ancis J. O Univer	Colli sitv E	ins Fi Blvd.	uneral	Home	Inc.	ng, MD 20901
	te e		23a. Part1. En er the disease, or composhock, or heart failure. List only o	lications that caused the	ne death. Do								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Acute My								j	Onset and Death
	/Medical		resulting in death)	Due to (or as a			HEUL COLU	41					
	Examiner	_	Sequentially list conditions,	Coronary			sease						
	ted nsit	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a									
	al-trai	Examiner	that initiated events resulting in death) Last	c. Atrial F  Due to (or as a			n						
0,00,	ifficate be executed g physician and as the burial-transit	edical		d.									
0			_										
Š	th cer rendin	sician/M	230. Was decedent pregnant	23c. If yes, outcome pt 1□Live birth 2		3 □E	ctopic pregnancy					ate of del	•
	e dea he at led fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at til			Other (specify)				"	1onth	Day Year
Ċ	The law requires that the death cert the has been signed by the attending age 2 should be detached for use	Phy	9 ☐ Unknown  Part II. Other significant conditions co	atributing to dooth but	not reculting in	a the und	orlying course sive	on in Bort I		220 Did tol	22000 1100 00	atributa ta	the cause of death?
'n	signe	þ	Fart II. Other significant conditions co	nuibuling to death but	not resulting ii	Title unu	enying cause give	en in Faiti.					robably 4XDUnknown
cords,	v requ	Completed							_				
ב ב	he lav	mp							-	24a. Was a autops perform	sy	prior to death?	itopsy findings available completion of cause of
D.	ifficate or, pa	င္ပ	25. Was case referred to medical					26 Place of	f Dooth (C	1 Yes :		1 ☐ Yes	2 No
>	ysicia is cert direct	0 B	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Ou	ıtpatient	3□ DOA Othe	NF:			ence 6 🗆 C	ther (Spe	cify)
5	ter th	Ë	27. Manner of Death	28a. Date of Injury (Month, Day	28b.	Time of	28c. Injury Work				ow injury occ		0,
5	endir ath. or: Af	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, 2dy		,,		Yes 2 □ No					
Ž	or Att ter de lirect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	r - At home, fa (Specify)	ırm, stree	t, factory, office		28f.	Location (St City or Town	reet and Nur n, State)	nber or Ru	ıral Route Number,
ב	urs al urs al erai D		29a. Certifier 1 Certifying Phy	alelen. To the book of					-1		( ) (		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to ompletely filled in by the funeral director, page 2.	Medical	(Check only one)	sician: To the best of Iner: On the basis of e and manner state	xamination ar	nd/or inve	stigation, in my of	pinion, death	occurred	at the time, d	ause(s) and l	nanner as e, and due	e to the cause(s)
	To the vithing To the Comp	Me	29b. Signature and title of certifier	N-			29c. License	number					h, Day, Year)
,	17-41		· sone	str	an	M.	0 36	192		/	VIARO	H, 6	07,08
	10		30. Name and address of person who co Anees Ahsan, MD	ompleted cause of dea 7610 Car				Takom	ıa Paı	ck, MD	20912		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0 2008	2. Registrar	s Signature	boss	E)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Lee Truitt 2008 much /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAUSBUM Wicomico Peninsula RegioNAL COMU 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1**⋉** M 2□ F Days Hours Min 73 214-30-9293 Director 4/26/1934 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a. State 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 ☐ No Wicomico Director Maryland Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21804 29519 Jackson Road USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23s. Ity or other traumatic event, the Medical Examiner must by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married white 1 ☐ Yes 2 🗓 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) management A & P Food Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Ralph Truitt Margaret Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other trai 29519 Jackson Rd., Salisbury, MD 21804 Naomi J. Truitt/wife 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/7/08 Salisbury, MD Park 1. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 avid A Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a conseque attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician 7Medical** Examiner

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

certificate has this

law requires that the death certificate be executed funeral director, After t within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu ō

State Registrar

Certification:

Medical

No 🎉 1 ☐ Yes 27. Manner of Death 1 Natural

2 Accident

4 ☐ Homicide

(Check only one) 29b. Signatur

3 ☐ Suicide

29a. Certifier

5 ☐ Pending investigation

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 □ DOA

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

21801

29d. Date signed (Month, Day, Year) 08

30. Name and address of person cause of death (Item 23a) (T

31. Date filed (Month, Day, Year)

MAR 0 7 2008

egistrar's Signature

DHMH 17 Rev 1/2001

08-02078 Madison Renae	Tho	Please Type or Print  State of Mary	in Black Indelible in and / Department or				ble.	
		1- For State Registrar	Certificate of	f Death		Reg	. No.	10 0026
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last)  Madison Renae	Thompson			2. Date of Death Month I March 14, 2		3_Time of Death () 1150 hrs
Agr.		4a. Facility Name (if not institution, give street and r St. Mary's Hospital	number)	4b. City, Town, o Leonardtov	r Location of Death		4c. County of Dea St. Mary's	ith
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yes		8. Date of Birth	(MM/DD/YYYY) 9. B	sirthplace (State or
Director		220-79-1521 1 M 2 X F	Yrs	Months Day		11/10/1	007 Fore	<sup>Sountry)</sup> Maryland
		Usual Residence of Decedent						10d. Inside City Limits
ow any		10a. State 10b. County	10c. City, Town or Local					1 Yes 2 X No
rryland ta-f sh	ctor	Maryland St. Mary's  10e. Street and Number		Californ 10f. Zip Code	1a	10g	. Citizen of What Co	ountry?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	22529 Joan Drive		20	619		United St	ates
with 1 with be not		11. Mantal Status 12. Was D	ecedent Ever in U.S. 13. Wa Forces? If Y	as Decedent of H	ispanic Origin? ( Spe	ecify Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,
r death	Funeral	1 Yes	2X No					
ural".	ρ	3 Widowed 4 Divorced If Yes, Give Yor Dates:  15. Decedent's Education (Specify only highest gr		Yes 2 X N	o specify: ation (Give kind of we	ork done	16b. Kind of Busines	iite s/Industry
72 hou n "nat	etec	Elementary/Secondary (0-12) College	(1-4 or 5+) during n	nost of working lif	e. DO NOT use retire	ed)		
5-0036 led within 7 Hygiene. I other than	Completed	0 0	Nev	ver Work	ed 18.Mother's Name	(Eight Middle M	Never Wo	rked
215-0 be filed on that Hyg	Be C	17. Father's Name (First, Middle, Last)	C			ina Rae		
212 ould be ould be in mark	To E	Shawn Patrick Thompson  19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Stre			er, City or Town, Sta	ite, Zip Code)
MD d 2 sho lith and m 27 is			Mother 22529			ifornia.	Maryland	20619
Ore, es lan of Hee If ite		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal	from State crematory or or	ther place)				
Baltimore, permit. Pages 1 a Department of He Important: If it	d	4 Donation 5 Other Specify: 21. Signature of Funeral Service License	Charles Me	emorial Name and Addre				
Bal permi Depar Impo injur		Shawn Aylesworth	O many III		DI.			Home, P.A. ID 20650-0279
Physician		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.	caused the death. Do not enter	the mode of dying	g, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Complic	cations of neonatal	E. Coli u	ırosepsis/me	ningitis a	and prematur	ity Death
		or condition resulting in death)  Due to (or as	a consequence of):					
	iner	if any, leading to immediate Due to (or as	a consequence of):					
	Examir	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as	a consequence of):					
cuted ind transit	_	d			<del></del>			
IOX 68760, eath certificate be execut eath certificate be execut eathering physician and for use as the burial - tra	sician/Medical	UNPENDED AMENDED	7,perME,g879 5/8/0	08 TT				
68760, certificate bunding physic	n/Me	IF FEMALE: 23c. If yes 23b. Was decedent pregnant in the	s, outcome of pregnancy	etal death 3	Ectopic pregnar	ncy	23d. Date of deliv Month	ery Day Year
X 60 th cert attendir	sicia	4 Ver O White O University	gnant at time of death 5 0	ther (Specify)				
اهية ي	Phys	Part II. Other significant conditions contributing	nown	underlying cause	e given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
P.O.	ð	Tare in other digital delications (Sharbaan)	to dodin but not recoming in the		<b>3</b>	1 Yes	2 No 3 P	robably 4 🗹 Unknown
cords, P.C. Law requires that has been signed to e 2 should be deta	Completed					24a. Was a		autopsy findings available to completion of cause of
ecol ne law te has ge 2 sl	dmo			<del></del>		perform	ned? death	?
Vital Records, hysician: The law requir this certificate has been s director, page 2 should!	Be Co	25. Was case referred to medical		26.Pla	ce of Death (Check o			
Vit;	To B	examiner? 1 Ves 2 No Hospital: 1	Inpatient 2 ER/Outpatien					her:
n of ding Pt	on:	27. Manner of Death  1 X Natural 5 Pending	te of Injury hth, Day,Year) 28b. Time of		jury at Work? Yes 2 No	280. Describe n	ow injury occurred	
Division tal or Attendi rrs after death.	icati	2 Accident Investigation 28e. Pl	ace of Injury - At home, farm, stre			28f. Location (Si	treet and Number or	Rural Route Number, City
Div vital or urs afte ral Dir	Certification:	3 Suidde 6 Could not be determined (Specification of the determined)				or Town, St		
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filted in by the funeral director,		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge, death occu	urred at the time,	date and place, and	due to the cause	e(s) and manner as s	tated.
To the within To the comple	<b>l</b> edical	one) 2 Medical Examiner: On the basi and manne	s or examination and/or investigates stated.			t trie time, date a		
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year  O.C.M.E.  March 15, 2008								

State 31. Date filed (Month, Day, Year) wistrar MAR 1 9 2008 Registrar

DHMH 17 Rev 1/2001 OCME 2006

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 8 2008 ear **Physician** 6:00 P M Mildred Alice Wajda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 8604 Imperial Drive Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 2, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 X F 1913 Massachusetts 95 027-05-8379 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2X No Director MD Prince George's Laurel 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20708 USA 8604 Imperial Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes X No Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than Registered Nurse Healthcare permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygie Important: If item 27 is marked other ti any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helena Twarog Felix Maslanka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8604 Imperial Drive Laurel, MD 20708 Louis W. Wajda/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State Chesapeake Crematory 03/11/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 The MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical ove to (or as a consequence of): phermoned condition de la 8 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Du Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed certificate Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only order Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes \2 ☐ No 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marie A. Dobyns, M.D. 7350 Van Dusen Rd. Suite 320 Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Webster Lloyd Ray March 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Regional 11comico Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Security Number **Funeral** Months 1 X M 2 □ F 215-18-4094 85 2/20/1923 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 No Wicomico Salisbury Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21804 910 Spring Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married 1 ☐ Yes 2 ☑ No Specify: ð white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) telephone company lineman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Tyler Carl David Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 910 Spring Ave., Salisbury, MD 21804 Doris May Webster/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/10/08 Salisbury, MD Shad Point Cemetery Security of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Kenal **Physician** /Medical Due to (or as a consequence of): Examiner Due to (% as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and I for use as the burial-transit Repraetor Due to (or as a densequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attendivibility and the Hours are death.

To the Funeral Director: All completely filled in by the fu

1.804-81

215-

(Check only one)

29b. Signature and title of certifier

Babulal Das

31. Date filed (Month, Day, Year) MAR 1 0 2008

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

29c. License number

057952

Milford ST # 504 B. Salisbury MDZ180)

29d. Date signed (Month, Day, Year)

03/06/08

			For State Registrar	;	State of Ma	ıryland		irtment of H <i>tificate of l</i>			giene Reg. No.	2008	093	167
P	hysicia	an	1. Decedent's Name (First, M.	,						2. Date of De Month	Day	Year	3. Time of I	
	/Medic	al	4a. Facility Name (If not institu		n A. Yank	ær	ï	4b City Town or	Location of Death	March	9 4c. 0	2008 County of Death	8:40	P <sup>M</sup>
	Examin	er	Ellicott City			ab		•	tt City			Howard		
	uneral rector		5. Social Security Number 064 05 1826	6. Sex 1 □	7. Age	e (In yrs. las 90	st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept 29	rth ay, Year) 9, 19:	9. Birth Cou Ne	place (State or ntry) w York	Foreign
and	M. J.		Usual Residence of Decedent 10a. State 10b. Cou			10c. City,	Town or Lo	cation					10d. Inside City	y Limits
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th the	or 28a e notii	Director	10e. Street and Number	ara				10f. Zip Code			10g. Citiz	en of What Cou	intry?	
ath wil	23a c ust bi	ral	9810 Old Anna					2104				ited St		
G Z IZ 13-0030 filed within 72 hours after death with the Maryland Hygiene.	Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ N  3 □ Widowed 4 □ Divor	Married	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:			Nas Decedent of H f Yes, specify Cuba I ☐ Yes 21x1 No	ispanic Origin? (S In, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh		
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iled w Hygiel	ther th nt, th		12 17. Father's Name ( <i>First, Mid</i>	dle. Last)			<u>I</u>	Iomemaker	18. Mother's Nan	ne (First, Middelle		wn Home		
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permit.   Departm	Importar any inju once,		21. Signature of Funeral Sen		ith 1	40104	4 22	Name and Address	ss of Facility Har olumbia	rry H. V Pike Ell	Witzk licot	e's Fam t Citv,	ily FH MD 210	Inc.
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	ysician and e burial-transit	edical Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c. d.	Due to (or as									
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ords, r.O	n signed by Ild be deta	by	Part II. Other significant con	ditions cont	ributing to death b	ut not result	ting in the u	nderlying cause giv	en in Part I.			se contribute to ☑No 3☐ Pro	li a	eath? Jnknown
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DIVISION OF VITA  To the Hospital or Attending Physician; within 24 hours after death,	<b>To the Funeral Director:</b> Afte completely filled in by the fune	Certification:	3 Suicide 6 □ Co	nding estigation uld not be termined	(Month, Day 28e. Place of inju- building, etc.	ury - At họn			k? Yes 2∐No	28f. Location City or To	(Street and own, State)	d Number or Ru	ıral Route Num	ber,
e Hospita 24 hours	e Funeral etely filled	ledical C	29a. Certifier 1X Cert (Check only 2 Med	ifying Phys ical Examin	ician: To the best er: On the basis o and manner sta	f examinati	vledge, deat ion and/or in	h occurred at the ti	me, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s	i)
To th within	<b>То th</b> сощр	Me	29b. Signature and title of ce	٤ (	I ams				30641		Ma	e signed (Monti	2008	
80°	-		30. Name and address of per Rameh Sab	son who cor	npleted cause of d	leath (Item :	23a) (Type,	Print) Cle River	Neck	- Road	1 13a	thme	ore Ma	12/22
4	Sta Regist	ate rar	31. Date filed (Month, Day, )		32. Progistr	ar's Signatu	ure	herts						

Registrar DHMH 17 Rev 1/2001 Sperte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician MARCH 24:30AM nard 21 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 216-34-545 1**M** 2□ F Director 122 ennsch Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, <u>the Medical Examiner must be notified</u> at 1 ☐ Yes 2 No Director Ha 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1601 death \ Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 17/Pather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 Is marked o 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Nur ber. City or Town, State, Zip Code) Men permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other Method of Disposition 1 ☑ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other) 3 ☐Removal from State 2ie 08 4 Donation 5 Other (Specify) tall 22. Name and Address of Facility 3 21. Signature of Funeral Sentice Ligensea FORST HALMD 21050 Tackville Evans Funeral Chapelo (romo 23a. Part1. Enter the disease, shock, or heart failure. r complections that cause the death. Do not enter the mode of dying, such as car liac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LEFT VENTRICULAR RUPTURE 10MINUTE /Medical Due to (or as a consequence of): Examiner INFERIOR MYOCARDIAL INFARCT 48 HOURS ocus titally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit YEARS CORONARY ARTERIOSCLEROSIS Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be HEMORRHAGIC PULMONARY EDEMA 3 ☐ Probably 4 ☐ Donknown 1 ☐ Yes 2 ☐ No has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an AORTIC STENOSIS autopsy performed? page certificate 2□No 10 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient ပို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to the cause (s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JAT40200157 D14873 5 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar IAMES

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31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

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32. Registrar's Signature

OSLER DRIVE.

TOWSON.

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 2008 11:34 p<sup>M</sup> Arbogast Howard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Riverview Care Center Essex Baltimore 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Month, Day, Year) NOV 23 1933 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 74 Director 234-54-1449 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- "any injury or other traumatic events." 10c. City, Town or Location 10d. Inside City Limits 10a. State 1-Yes 2 No Director MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7601 Carson Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Follows 1 X Yes 2 No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 Married 1 □ Yes 2 X No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Operator Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McCloud Lawrence Arbogast ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ilene Arbogast - Wife 7601 Carson Avenue, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/24/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. <sup>22</sup> Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPITUTION Theumonia Physician /Medical Due to (or as consequence of): Examiner Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 st autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the de 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number ノンコ D0061907 name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Bultimore, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAR 2 5 2008

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician / Medical Examiner  The proposal of the property of			23a. Part 1. Enter the disease, or compositock, or heart failure. List only	lications that caused the death.	Do not ente	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Betwee	en
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FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   No   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy performed autopsy perfor	e be ex sician burial			d	stice of/.							
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28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28c. Injury at Work?  28d. Describe how injury occurred			examiner?				26. Place of Dea			T Tes	2 140	
Month, Day Year) Injury Work?	1 3 3 3 3 3 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5	္	1 ☐ Yes 2 ☑ No	inpatient 2∐E		1 3 DOA	4 LI Nursing F				)	
3 Suicide 4 Homicide 5 City or Town, State)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	ling After fune	tion	1 Natural 5 ☐ Pending	(Month, Day Year)				28d. Describe	now injury c	occurrea		
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month. Day. Year)	Hospital 24 hours Funeral etely filled		(Check only 2 Medical Exam	iner: On the basis of examination	on and/or inv	estigation, in my o	pinion, death occ	urred at the time,	date and pl	lace, and due to	ated. the cause(s)	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	To the To the Within To the Compl	Me	29b. Signature and title of certifier			29c. License	number		29d. Date s	signed (Month, i	Jay, Year)	
Bharet Monga ms 89582 3/10/08			Bharet	monga mo	,	80	1582		2/1	0/08		
and manner stated.  29b. Signature and title of certifier  29c. License number  3/10/08  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Bhart Monga M. J. O. Maryand Gerral Hospital  31. Date filed (Month, Day, Year)  32. Registrar's Signature			30. Name and address of person who can also an area of the second of the	, M.D. 90 1.	23a) (Type, F	Cyland (	Sitnera	1 Ho	prta	l		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar  MAR 2. 5. 2008				200	ure done	10 P						

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 2008 B XI /Medical 4a. Facility Name (If not institution, dive street and number) Town, or Location of Death uty of Death Examiner / Au dr שר מער ה 10 ath was If Under 1 Year 8. Date of Birth (Month, Day, Yea Mar. 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1X M 2 □ F ĩ922 Yrs 86 MD 214-16-8775 Mar. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. In the Maryland in the T is marked other than "hatural", or items 23a or 28a-f show unt: if item 27 is marked other than "hatural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Reisterstown Directo MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 6500 Deer Park Road 21136 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Consultant Restaurant Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Aquila Anna Battaglia ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Deer Park Road, Reisterstown, MD 21136 Wife Anna Aquila 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If ite any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-28-08 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park Sykesville, MD 21. Signature of Fun 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the greea, e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear all of List only one cause on each line. Immediate Cause (Final **Physician** ocmedia! disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown cate has been sig , page 2 should b 2 No 3 Probably 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate ! 1□ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred + ☐ Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

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DHMH 17 Rev 1/2001

Registrar

29a. Certifier

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31. Date filed (Month, Day, Year) MAR 2 5

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Medical

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son who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

🛨 Certifying Physicían: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

our dond Amortho

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24th Brown 530 AM 2018 March /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Hours 54-1441 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Elli Cott 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 21043 USA 3000 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Print) (Sister) 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOACE leman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Specify) カmore 21. Signature of Funeral Service Licensee

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

physician and s the burial-trans attending pl cate has been signed by the page 2 should be detached within 24 hours after death.

To the Funeral Lirector: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

	Varishn	C. Belline 5:51 Baltimore	Vatil Pike	Baltin	we.Md 21229
	23a. Part1. Enter the sease, or comp shock, or heart failure. List only of	lications that caused the death. Do not enter the mode of dying, such as cardiac one cause on each line.			Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. End Stage Renal Discase  Due to (or as a phosequence of):			Oriset and Dealin
l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Digital Mellits  Due to (or as a consequence of):  Due to (or as a consequence of):			
dica		d			
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of deliv Month	ery Day Year
ed by Ph	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2		the cause of death?
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Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	1 ☐ Yes 2 🗗 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5 Residence	6 □Other (Speci	fy)
Certification: T	27. Manyrer of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how inju	ry occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street ar City or Town, State	nd Number or Rur e)	al Route Number,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) 32. Begistrar's Signature

MAR 2 5 2008

State Registrar 08-02166 Çu

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urtis A. Blach	е	1-	For State	State	e of Mai	ryland / Depa Cer	rtment of		and iv	nentai myg		NI-			
Physic	ian/	Re	gistrar Decedent's Name (	First, Middle,Li	ast)		inouto or	Doda			Reg.		2013 ear	Time of Death	
Filysic le^∺≏al Exam			CUFTI	SA.		ache.					Month 17, 2	800.		2140 hrs	
		48	a. Facility Name (if r		ive street ar	nd number)	4	4b. City, Town, or Location of Death  Baltimore					y of Death		
		-	Johns Hopkin		Sex	7. Age (In yrs. I	ast birthday)	If Under		f Under 24Hrs.	8. Date of Birth	(MM/DD/YY	YY) 9. Birth	place (State or	
Funera Directo			216-33-0		2	-	Yrs.	Months	Days	Hours Min.	9.14	1979	Foreign Cour	ntry) Trinidad	
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vith the M. s 23a or 2	Fineral Director	1 1	1. Marital Status	11040	12. Wa	s Decedent Ever in U	.S. 13. Wa	s Deceden	t of Hispar	nic Origin? (Spe	ecify Yes or No-		ace - Americ	an Indian, Black,	
Seath v	lu lu		Never Married		1 1	ned Forces? Yes 2 100				exican, Puerto F	Rican, etc.)		01	- 0 1	
after (	4	S .	3 Widowed		ed If Yes, Gi or.Dates:			Yes 2		pecify: (Give kind of we	ork done	Specif		ndustry	
hours afte "natural",	Pa		15. Decedent's Edu Elementary/Secon			et grade completed) ege (1-4 or 5+)	during m	ost of work	ing life. Do	O NOT use retire	ed)				
36 thin 72 than than	Completed		19th				Suc	eryi	Sor	-		Stat	eaf	Maryland	
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alt de		-	20a. Method of Disp	osition		20b.	Place of Dispos crematory or ot	her place)			Date	20c. Locatio			
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Baltimore permit. Pages 1 a Department of He Important: If it			21. Signature of Fun	eral Service Li	censee		22.1	Name and	Address of	F cility Vau	Sho C G	reere	Funera	1 Services	
		1	Vauve	tisease or co	mplications	that caused the deat	h. Do not enter t	he mode of	f dying, su	ich as cardiac of	mre. M	est, shock, or	heart	Approximate Interval	
Physicia Medica		6	failure. List only	y one cause or	n each line.	le Gunshot Wou								Between Onset and Death	
xamine	er		Immediate Cause (F or condition resultin			or as a consequence									
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Box e death c the atten	d for u	Physician/M	1 Yes 2 N	lo 9 Unkn	9	Unknown	00							(1-4-7	
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tal Rec vian: The l certificate l	ector, page	5							26 Place (	of Death (Check	1 Yes	2 No	1 🗸 Y	es 2 No	
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Division of Vital Records, rat or Attending Physician: The law requirers after death.  10 Director: After this certificate has been si		읽	1 Yes 27. Manner of Deat	2 No	28	a Date of Injury	28b. Time of	Injury	28c. Injury	at Work?	28d. Describe Subject sho				
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ivis lor At after d	d in by	Certification:	3 Suicide		not be 28	Be. Place of Injury - At		eet, factory	, office bu	ilding, etc.	or Tours	State)		ural Route Number, City  Aveuve, Baltimore, Md	
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy			4  Homicide 29a. Certifier		7-	the best of my knowle	edge death occ	urred at the	e time, dat	e and place, and	d due to the cau	se(s) and ma	anner as sta	ated.	
the H hin 24 the Fq	npletel	Medical	(Check only one) 2	Medical Exan	niner: On the	basis of examination	and/or investig	ation, in m	y opinion,	death occurred	at the time, date	and place,	and due to t	he cause(s)	
To with	COL	ĕ	29b. Signature and	title of certifier		armer stated.		29	c. License					onth, Day, Year)	
			()	MAL 2					O.C.N	1.E.		March	18, 2008		
. 0		f				ted cause of death (It	em 23a)	Street	Baltimo	re, MD 2120	)1				
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			For State Registrar		State of Ma	ryland		artment of F rtificate of I		and Men		- (	1000	0.04	7 1
			Registrar  1. Decedent's Name (F	First, Middle, Last)	- ··		Cei	lilicate of t	Deam	2.1	Date of Deat	eg. No.	7000	3. Time of	Death .
	Physici /Medio		John	Α.		Baxt	ter				Month arch 2		2008 Year	8:30	
	Examir	er	4a. Facility Name (If no		ŕ			4b. City, Town, or		f Death			County of Death		
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į,	Director		081-18-678 Usual Residence of De	81 100	M 2□F	85	Yrs.	Months Days	Hours	Min (	Month, Day, pt. 3,	Year) 19	22 North	Caro	lina
	yland iow			b. County		10c. City,	Town or Lo	cation					1	0d. Inside Ci	ty Limits
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36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 🕅 Never Married 3 🔲 Widowed 4 🗆	2 Married	Armed Forces?  1 X Yes 2 N If Yes, Give Year or Dates: V	ю		Was Decedent of H f Yes, specify Cuba l □ Yes 2ሺ No	Specify:	gin? (Specify , Puerto Rica	Yes or No- n, etc.)		4. Race - Americ Black, White, Specify: R1:		
2-00	72 hou natura ical E		15. (Specify)	i. Decedent's Educ only highest grade	ation	- 1	16a. Deced	lent's Usual Occup	ation		- 1		d of Business/Inc	dustry	
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and	id be f ental ? ked ol	To Be	William Ba		•					1 Shaw		raiden s	surname)		
ary	2 should be and Mental is marked aumatic ev	ř	19a. Informant's Name				19b. Mailin	g Address (Street				City or	Town, State, Zip	Code)	
	1 and 2 Health a em 27 is		Milton Bax	<u>'</u>	phew)			Lincoln	Rd. B	rookly	n, NY	112	25		
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposit 1 ☐ Burial 2 ☐ C 4 ☐ Donation 5 ☐	remation 3 □Re	emoval from State	cerr	netery, cren	sition (Name of natory or other plac Cemetery		Date /28/08			ation - City or To en, New		у
3alti	permit. Pag Department Important: Is any Injury o		21. Signature of Furera	al Service Lice	271		22	Name and Addressealy Cuy	ss of Facility	uneral	Home.	LL	C		
			23a Parti Enter the d	nnes /	Umeen	the death		<u> 1084 Paci</u>	tic S	t., Br	ooklyr	1, N	Y 11238		
	Dharisis		23a. Part1. Enter the d shock, or heart fa Immediate Cause (Fina								spiratory arre	est,		Approximate Interval Bet Onset and D	ween
2	Physician /Medical		disease or condition resulting in death)	a.	Due to (or as a			ular a	CCIO	rent				unkn	own
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	Pg / ##	iner	Sequentially list conditions of the cause. Enter Underlyin	ng	Due to Lor as a	consequer	nce of								
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Ξ	siciar certif	) Be	25. Was case referred texaminer? 1 ☐ Yes 2 No	_	ospital:	+ 0CC	/O44i4	Othe		of Death (Ch					
0	ding Phys	n: To	27. Manner of Death		1 ☐ Inpatien	/ 28	b. Time of	28c. Injury Work	4 <b>/1</b> Nur		5 ∐ Reside Describe ho		Other (Specify occurred	/)	
Ö	ath. or: Aft	atio	2 Accident	Pending investigation	(Month, Day	Year)	Injury		<br Yes 2 □ N	lo					
Division or Vital Records,	r At ter d irec	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of injur building, etc.	y - At home (Specify)	e, farm, stre	eet, factory, office			ocation (Str City or Town,		Number or Rura	l Route Numi	ber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1X (Check only one) 2	Certifying Physic   Medical Examina	clan: To the best of er: On the basis of and manner stat	examinatior	dge, death and/or inv	occurred at the time time estigation, in my of	ne, date and pinion, deat	d place, and on the occurred at	due to the ca	use(s) a ate and p	and manner as st place, and due to	ated. the cause(s	)
8	To the within 2 To the complet		29b. Signature and title	was alle	1/				3/21			3/	signed (Month, 1)		
	N		30. Name and address of NURUL	of person who com	HURY,	ath (Item 23	(Type, F	Print) 2-16 DIN	10 DA	RIVE ;	BUK	ZTO	NSVILL	€, MI,	2086
	Sta Registra	(e													
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08-02295 James Blankens	shin	Please Type o								ble.		
James Diamen.	JIIIP	1- For State	of Maryland	-	cate of D		iu ivien	ıtaı Hygiei		21	nae.na	3.
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Las	t)		5010 O. D.			2. Dat	Reg. e of Death	No.	3. Time of Death	0
Medical Exami		James		Bla	ankensh	nin		Mor Mar	oth 23, 2	Day Year 008	1208 hrs	
1		4a. Facility Name (if not institution, giv	e street and number	)	4b. (	City, Town, o	r Location			4c. County of	Death	
1		Johns Hopkins Bayview M	edical Center		В	altimore						
Funeral		Social Security Number 6. S	7. Aç	ge (In yrs. last b		Under 1 Yea			,	1	Birthplace (State or Foreign	
Director		223-62-5961 <sub>1</sub> X	M 2 F	6	1 <sub>Yrs.</sub> 1	Months Day	ys Hours	Min. Ap	ril 7	,1946	Country) Virgin	nia
		Usual Residence of Decedent										
w any		10a. State 10b. County  Marvland Baltimo	200	10c. City, Tow	n or Location Oundalk						10d. Inside City Li	
land f sho	ō	1	re		unuaik						1 Yes 2 X	∆ No
Mary 28a-	Director	10e. Street and Number			10	of. Zip Code			10g	. Citizen of Wha	it Country?	
vith the Maryland s 23a or 28a-f show s e notified at once.		7847 Harold Road				212	222			U.S.		
th wit	uneral	11. Marital Status  1 Never Married 2 X Married	12. Was Deceden Armed Forces					gin? (Specify Y		14. Race - White.	American Indian, Black, etc.	
r dea or it	Fur		1 Yes 2	X No		s 2 X No			ŕ	Specify: V	White	
rs afte rral", miner	by	Widowed 4 Divorced  15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	mpleted) 16a				kind of work do	no 11	6b. Kind of Busi		
2 hour	leted	Elementary/Secondary (0-12)	College (1-4 or		during most				lie l	ob. Kind of Eds	ness/industry	
36 hin 7 e. than	ald (	12 years	00.10g0 (1 1 0.1	, i	Assemb.	ly Lin	e Wor	cker		Genera]	l Motors	
5-0036 fled within 7. Hygiene 1 other than	Comp	17. Father's Name (First, Middle, Last)					18.Mothe	r's Name (First,	Middle, Ma	iden Surname)		_
21215-0036 Modal Hygievithin 72 hours after annual Hygievithin "matural", cevent, the Medical Examiner	Be (	Harlin Blankenshi	q				Glad	dys Keer	ne			
21 ould I d Mer s mar	2	19a. Informant's Name/Relationship (7	ype, Print )				et and Nur	nber or Rural R	oute Numbe		, State, Zip Code)	
MD d 2 sho lth and n 27 is		Elizabeth Blanken	ship w	rife 7	847 Ha	rold R	Road,	Dundall	k,Mary	yland 2	21222	
		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from S		of Disposition atory or other p		emetery,	March	27.	20c. Location - (	City or Town, State	
MO Pages ent of int: J		4 Donation 5 Other Specify.	Removal from S	Sacred	Heart c	of Mary	Cem.	2008		Dundalk	, Maryland	
Baltimore, permit. Pages I ar Department of He Important: If ite		21 Fignature of Funeral Service Licen	see	20	22-Name	and Addres	s of Facilit			Dundalk.	РА	
<b>™</b> 5.5 5 <b>™</b>		Inthony	some	ller	711	0 So11	ers I	Point Ro	oad, Î	Dundalk, Dundalk,	MD. 21222	
Physician		23a. Part I. Enter the disease, or comp failure. List only one cause on ea		the death Do	not enter the m	node of dying	, such as o	cardiac or respir	atory arrest	t, shock, or hear	rt Approximate Inte Between Onset	
/Medical Examiner			Atherosclerotic	Cardiovasc	ular Diseas	se					Death	
Zammer		or condition resulting in death)	Due to (or as a cons	equence of):								
	-	Sequentially list conditions,	Due to (or as a cons	oguence of):			_					
	Examiner	cause. Enter Underlying Cause	Due to (or as a cons	equence or,								
¥ ±	Xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):								
executed ian and ial - transit	ical E	d.	1									
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Box 68760, e death certificate be executed. the attending physician and ed for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnanc	_			c pregnancy		23d. Date of d	•	
certil	Sar	past 12 months?	1 Live birth 4 Pregnant a	t time of	2 Fetal d	(Specify)	Ectopi	c pregnancy		Month	Day Year	
Boy death	ysi	1 Yes 2 No 9 Unknown	g death Unknown		o Other	(Opeciny)						
O. at the at the trache		Part II. Other significant conditions	contributing to deat	th but not resulti	ing in the unde	rlying cause	given in Pa	art I. 2:	3e. Did toba	acco use contrib	oute to the cause of death	?
of Vital Records, P.O. Box ing Physician: The law requires that the death After this certificate has been signed by the atte funeral director, page 2 should be detached for u	d by								1 Yes	2 No 3	Probably 4 V Unkno	wn
rds requi	ete							24	4a. Was an autopsy		ere autopsy findings avail ior to completion of cause	
Division of Vital Records, tal or attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed								perform Yes 2	ed? de	eath?	
H. Th		25. Was case referred to medical				26.Plac	e of Death	(Check only on		7 140	165 2 140	
/ita	o Be	examiner?	lospital: 1 Inpatio	ent 2 🗸 ER/6	Outpatient 3	DOA	Other	Nursing Home		esidence 6	Other:	
of \ g Phy free th	-1	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inj	ury 28b	. Time of Injury	/ 28c. Inji	ury at Work		home-of	w injury occurre	d	
OD on ondin	힐	1 Natural 5 Pending	(Month, Day,	rear)		1	Yes 2	No				
ivision  or Attend after death. Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not	28e Place of Ir	njury - At home,	farm, street, fa	ctory, office	building, e				r or Rural Route Number,	City
Div Ital o	ET.	Suicide 6 Could not determined						Or	Town, Stat	te)		
Di 24 hospital 24 hours & Funeral etely filled	음	29a. Certifier 1 Certifying Physici	an: To the best of m									
Division of Vital Rec To the Hospital or Attending Physician: The L within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page.	Medical	one) 2 Medical Examiner										
E. ½ E. 8	Me	29b. Signature and title of certifier	and marries stated.			29c. Licen	se number		2	29d. Date signe	d (Month, Day, Year)	
		1/1 1 11 7/	TO TO	440		0.0	.M.E.	OCME		March 24, 2	800	
.0	ŀ	30. Name and address of person who	completed cause of	death (Item 23a)	)		· <u>-</u>					
10		Theodore M. King, Jr., MD			niner 11	1 Penn St	treet, Ba	altimore, MD	21201			
St	ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signature								
Regist		MAR 2 5 200	8 Marine Care	2 /2	Bornett.	&						

08-022	36	3
Sherry	L	Burke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

herry L Burke		State of Maryland / Department of 1- For State Registrar Certificate of Registrar	
Physici ledical Exami		1. Decedent's Name (First, Middle,Last)  Sherry Lynn	Burke 2. Date of Death 3. Time of Death Month Day Year March 20, 2008 2209 hrs
		Franklin Square Hospital	City, Town, or Location of Death  Rosedale  4c. County of Death  Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 M 2 X F 37 Yrs.	If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or Foreign Country)   Manyland
l ow any E.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Essex	n 10d. Inside City Limits 1 Yes 2 XNo
e Maryland or 28a-f show any ied at once.	irector	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
ath with th items 23a ast be notif	Funeral Director	1 X Never Married 2 Married Armed Forces? If Yes	21221 USA  Decedent of Hispanic Origin? ( Specify Yes or Nos, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
Baltimore, MD 21215-0036 Deprnit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of St I and a Mondal Hygiewith 72 hours after death with the Maryland Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	res 2 X No specify: Specify: White s Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
5-0036 led within 72 ho Hygiene. I other than "na the Medical Ex	Completed	10 years House	st of working life. DO NOT use retired)  Sewife Own Home
21215-C und be filed v Mental Hygi marked oth c event, the I	Be	17. Father's Name (First, Middle, Last)  Ronald Anthony Burke  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing /	18.Mother's Name (First, Middle, Maiden Surname)  Janet E. Abusch
and 2 shoul lealth and N tem 27 is in traumatic	70		Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Verside Road, Essex, Maryland 21221  on (Name of cemetery, Land Date of 120c, Location - City or Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite		Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  Crematory or other Bayview Crematory or other Specify:	rematory 2008 Baltimore City, MD.
Physician Physician	J 18	22. Na COL COLOR Service Licence 22. Na COL COLOR SERVICE SERV	me and Address of Facility INELTY Funeral Home Of Dundalk, P.A.  0 Sollers Point Road, Dundalk, MD. 21222  mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate  True Frie II deflying Course  Due to (or as a consequence of):	
recuted n and - transit	Examine	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):	
60, ate be exec thysician are the burial - t	Medical	X UNPENDED AMENDED 23a, 27, 28a—f per ME  IF FEMALE: 23c. If yes, outcome of pregnancy	g878 4/4/08 amh 23d. Date of delivery
Box 6876( e death certificate the attending phy ed for use as the be	Physician/M	23b. Was decedent pregnant in the past 12 months?	I death 3 Ectopic pregnancy Month Day Year or (Specify)
, P.O. E res that the d signed by the be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the uncontributing to death but not resulting in the uncontributions.	derlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
cords law requi has been	Completed		24a. Was an autopsy prior to completion of cause of death?
Vital Registraters are director, page	å	25. Was case referred to medical examiner?  1 ✓ Yas 2 No.  Hospital: 1 Inpatient 2 ✓ ER/Outpatient	26.Place of Death (Check only one)  Other Nursing Home 5 Residence 6 Other:
ion of V tending Physeath. tor: After thi	tion: To	27. Manner of Death  1 Natural 5 Pending Fnd 3/20/08 Fnd 10:09	ury 28c. Injury at Work? 28d. Describe how injury occurred
Division  Hospital or Attend 24 hours after death Funeral Director:	ertification:	2 Accident Investigation 3 Suicide 6 X Could not be determined Homicide Homicide Investigation 28e. Place of Injury - At home, farm, street, (Specify)	
To the Hospita within 24 hours To the Funeral completely fille	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place, and due to the cause(s) and manner as stated.  n, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	Me	29b. Signature and title of certifier  Passatth Say Holl, MI)	29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  March 21, 2008
			Penn Street, Baltimore, MD 21201
St Regist		31. Date filed (Month, Day, Year) 32 Registrar's Signature	OGME
HMH 17 Rev 1/20	001	ORIGINAL	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registamend #20a-c&22 Per FH G877 3/Q5/108cata of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 13, 2008 **Physician** 12:12 PMM Oris Butler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 4, 1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Washington DC 69 Director 577-52-6743 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2√□No Director MD Prince George's Forestville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7420 Marlboro Pike 20774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sanitation worker District of Columbia unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anne Mae Boykins Charles Butler မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 Country Club Drive Conyers, GA 30013 Maria Allen/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 ☐Removal from Stat MT. Carmel Cen. 3/27/2008 Baltimore, MD. 4 ☐ Donation 5 ☑ Other (Specify) in state Rohald Taylor Baltimore, MD 21. Signature of Euneral Service Licensee Ronald S. Wade, Director 23a. Part. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or result and the cause of death and the ca Immediate Final disease or condition resulting in death) Bilateral Premionia with her water **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transi attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the aid be detached for 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2☐No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29c. License number 29b. Signature ar March 13 2008 00055120 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Richard

31. Date filed (Month, Day, Year)

Adviner

MAR 2 5 2008

MO

Suite 310 Wartington DC 20032

1328 Southern avenu SE

3 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 21, March 11:14p M Chris R. Bomhardt 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard Co. Glenwood 2889 Hunt Valley Drive 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Mary Land 1**⊠**M 2□F 61 215-46-8558 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Glenwood Howard Co. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21738 2889 Hunt Valley Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Steel Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Randall Harry L. Bomhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 2889 Hunt Valley Drive Glenwood, MD 21738 Phyllis A. Bomhardt-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3-24-08 Baltimore, MD 22. Name and Address of Facility Raczorowski Funeral Home, PA 21. Signature of Funeral Service License Tolunt 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to for as a consequence of Due to (or as a consequence of):

**Physician** /Medical Examiner

permit. Pages 1
Department of H
Important: If Ite
any Injury or oth

**Physician** 

/Medical

Examiner

10a State

MD

Director

Funeral

Completed by

Be

2

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hyglene.
nnt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show runt: If Item 27 Is marked other than "natural", or Items 25a or 28a-f show nnt; If Item 27 Is marked other than "nature and the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury **W**atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier

23d. Date of delivery Month Dav

23e. Did tobacco use contribute to the cause of death?

Year

3 ☐ Probably 4 ☐ Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 1∐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number 29b. Signature and title of certifier com

29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers

St. Paul Place Baltimore, Maryland 21202 Feldman, M.D. 22 227 Jack Marvin 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

10

Medical

MAR 25 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State end #20b Per FH G878 4/04/08 TH G878 4/04/08 Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Nancy 3 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE-WASHINGTON MEMORIAL GLEN BURNIE ANNE ARUNDEL Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2₩F Hours Months Min. Director 53 219-66-4232 Usual Residence of Decedent 7/24/1954 MARYLAND 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County show r 28a-f sh notified a 1 ☐ Yes 2 ☐ X o Director MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe or "natural", or items 23a 110 GEORGIA AVE. N.W. 21061 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 12 item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OWEN WILSON DeLAWDER JO ELLA WOOD ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA JOHNSON -DAUGHTER 110 GEORGIA AVE., N.W., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY BALTIMORE, MD <del>9/08</del> 4 ☐ Donation 5 ☐ Other (8pecify) 21. Sign your Tuneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) minutes /Medical Due to (or as a consequence of) Examiner ardiac Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed and Due to (or as a consequence of): burial Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) by the a 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Vinknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 certificate had irector, page 2 1 ☐ Yes 2 ☐ No tai or Attending Physician: The safter death.

I Director: After this certificate ed in by the funeral director, pa 1∏ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Within 24 hours are To the Funeral Dir 🛚 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4115 Ritchie Hwy MD Brooklyn, MD 21225 Erika N. Kane,

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 09380 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician 6:20 P.M 23, 2008 Helen Callow March /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 1, 1915 92 Dec. Washington D.C. 579-32-7127 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show at 1 ☐ Yes 2 X No r 28a-f sh Director Maryland Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or e within 72 hours after death with items 23a c iner must be 21045 8220 Snowden River Parkway USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or item edical Examiner n Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Modulo 000. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Stevenson James Stephanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theresa Walter Daughter 1103 Sedgewood Road; Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Metro Crematory rematory 3/26/2008 Catonsville, Maryland
22. Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month Physician asci Cly 640 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner and Due to (or as a consequence of) HELEN CALLOW
Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ◯ No 24a. Was an page 2 autopsy performed' 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (It m 23a) (Type, Print) ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 M.D.2. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City. Town, or Location of Death

2. Date of Death

March 21,

Day

2008

4c. County of Death

Baltimore

14. Race - American Indian,

White

MD 21228

23d. Date of delivery

Dav

2 No 3 Probably 4 Unknown

1 □ Yes

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

Approximate Interval Between Onset and Death

Year

Black, White, etc

3. Time of Death

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

1 □Yes 2XNo

2:45 P. M

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Frances O'Ferrall\_Costello

4a. Facility Name (If not institution, give street and number)

1004 Magruder Avenue

**Physician** 

/Medical

**Examiner** 

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 25

Medical

State

Registrar

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and aptiess of person who completed cause of death (Item 23a) (Type, Print) ROAD, SUITE DOY, CATONSWILLE, M.D. 2128 SCOTT POULTON, MD 405 FREDERICK ROAD, SUITE DOY, CATONSWILLE, M.D. 2128

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per dr., g877 g031/251608dbbath Reg. No. 3. Time of Death 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 **Physician** COLLINS ARBARA /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Year If Under 24 Hrs. 9. Birthplace (State or Foreign yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 X F 2 Yrs Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ es 2 ☐ No Funeral Director MD Itimore 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ Vo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>ک</u> 3 ☐ Widowed Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Elementary/Secondary (0-12) College (1-4or 5+) 17. Fathe 's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licenses St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism **Physician** /Medical Due to (or as a consequence of): Respiratory Arrest Examiner Sequentially list conditions, if any, leading to infill order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardiac Arrest The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à certificate has been signed rector, page 2 should be del 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 paratient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours atter death. To the Funeral Director: ₽ 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of confifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1 A MI MBACHEN on 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State o	of Marylan		artment of H rtificate of L		nd Me	, ,	and the contract of	3 8	09383
			1. Decedent's Name (First, Middle	e, Last)					2	2. Date of Deat	h		3. Time of Death
	Physici /Medio		Alice Faye	Clar	k					Month March	20, 200	Year B	8:47 pm
1	Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or	Location of			4c. County		
df. or		٥	609 Dale Avenu				Overlea				Baltin		
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs.	la <i>st birthday)</i> Yrs.	If Under 1 Year  Months Days	If Under 24 Hours	Min.	<ol> <li>Date of Birth (Month, Day,</li> </ol>	Year)	Coun	
	Director		234–22–2524 Usual Residence of Decedent		75	113.				May 16	, 1932	West	Virginia
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	0d. Inside City Limits
	a-fs	ctor	Maryland Balt	imore	Esse	ex							1∐Yes 2∐XNo
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of W	hat Coun	try?
	s 23a	rai	1 Brett Court	Apt 225			21221			Ţ	J. S. A.		
ပ္	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marchal Evanthas must be natified at once.	Funeral	11. Marital Status 1 □ Never Married 2 □ Marr	ied Armed Fo	2 No	S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	spanic Origi n, Mexican,	n? (Spec Puerto Ri	ify Yes or No- ican, etc.)		- Americ , White, e	an Indian, etc.
21215-0036	ural", d	d by	3X Widowed 4 □ Divorced	If Yes, Gi Year or D	ve		1∐Yes 2∭XNo	Specify:			Specify:	Whi	.te
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Maryland	ld be lental ked c	To B	Dan Spauldi	na				Marv		Canter	_	•	
ary	shou and N s mai		19a. Informant's Name/Relations			19b. Mailin	g Address (Street a					State, Zip	Code)
Σ	and 2 salth 3 127 i		David Lee Clar	k (Son)		609 T	Dale Aveni	ie Ov	erle	a. Mary	vland 21	206	
ore	les 1 of He if Iten		20a. Method of Disposition 1X Burial 2 ☐ Cremation		20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place	,	Dat		20c. Location - (		wn, State
Ē	. Рад tment tant: jury с		4 □ Donation 5 □ Other (S		State		l Mem. Ga	1	3/26 2008		Middle	Rive	r, Maryland
Baltimore,	Depar Mpor Iny in		21. Signature of Funeral Service	Licensee		22 B1	Name and Addres	s of Facility	ral				
	40 = 60		Pluchow C.	Jaffin,	Sr.	172	uzdzinsk 107 old E	stern	Ave	nue Es	ssex, Ma	ryla	nd 21221
			23a. Part 1. Enter the disease shock, or heart failure. List Immediate Cause (Final	only one cause on e					ardiac or I	respiratory arre	est,	,	Approximate Interval Between Onset and Death
The same of the sa	Physician /Medical		disease or condition resulting in death)	a	Lung	1 00	arcino	Ma					
1	Examiner			Due to	(or as a consequ	lence of):							
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D	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Ö,	e exe ian al urial-t	EX	resulting in death) Last	Due to	or as a consequ	ence of):							
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9 X	#= F S		IF FEMALE:	00.1/									
Вох	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live I	come of pregnar pirth 2 ☐ Fetal	death 3	Ectopic pregnancy				23d. Date Mon		ry Day Year
o i	uires that the de signed by the a d be detached	ysic	1 □Yes 2 ☑No 9 □ Unknown	9 ☐ Unkn	nant at time of de own	eath 5∟	Other (specify)						,
J	that ned b		Part II. Other significant condition	ns contributing to de	eath but not resu	Iting in the un	derlying cause give	n in Part I.		23e. Did tob	acco use contri	bute to th	e cause of death?
Vital Records,	law requires that the as been signed by the 2 should be detache	ed by								1 √le	s 2 🗆 No :	3 ☐ Proba	ably 4 🗌 Unknown
ပ္တ	law requir as been s 2 should	olete								24a. Was an	24b. W	ere autop	osy findings available
ř	<u>ө</u> <u> </u>	Completed								autopsy	/ pi ngd? de	ior to con eath?	npletion of cause of
<u>=</u>	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					26. Place of	f Death (6	Check only one	*)	□Yes	
5 d	nysic this ce	2	1 ☐ Yes 2 XNo	Hospital: 1 ☐ I	npatient 2 🗆 E	R/Outpatien	3 □ DOA Othe	r: 4 ☐ Nursi	ing Home	5 ☐ Reside	nce 6XX0the	r (Specify	Son's Residence
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Sic	trend Jeath tor: /	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation				es 2□No					
DIVISION	or to Robshale of Attending Physician: within 24 hours after cleath.  To the Funeral Directors. After this certific completely filled in by the funeral director, I	Certification:	4 ☐ Homicide determi	ned 28e. Place buildir	of Injury - At hor ng, etc. <i>(Specify</i>	ne, farm, stre )	et, factory, office		28f	f. Location (Str City or Town,	eet and Numbe State)	r or Rural	Route Number,
	pspita hours ineral		29a. Certifier 1 Certifyin	Physician: To the	best of my know	vledge, death	occurred at the tim	e, date and	place, an	d due to the ca	use(s) and mar	ner as st	ated.
1	in 24 the Fu	edical	(Check only 2 ☐ Medical in one)	examiner: On the ba	asis of examinati ner stated.	ion and/or inv	estigation, in my op	inion, death	occurred	at the time, da	ite and place, a	nd due to	the cause(s)
	To To Tro	2	29b. Signature and title of certifier	, 5	N.		29c. License	number	_	29	d. Date signed	(Month, E	Day, Year)
			P Uhuk	(8 D>=	, 1	1 D	1700	610	105	7	3/21/	08	
	D		30. Name and address of person v	vno completed cause	e of death (Item 1124		ce Ave	rue	, Ba	ultimo	re M	D	21221
	Stat	e	31. Date filed (Month, Day, Year) MAR 2 5	32. Re	egistrar's Signatu		- Al						

DHMH 17 Rev 1/2001

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Division or Vital Records, P.O. Box 68760,	o the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after clearly	offer this certificate has been signed by the attending physician and

				Please	Type or Prin					-			
			For State Registrar		State of Ma	aryiano		rtificate of		Mental H	ygiene Reg. Na	one the the time	09384
1	7-1-7		1. Decedent's Nam	. Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of		
		Physician /Medical Flossie Mae Coles								March	March 22, 2008 7:55		
	Examin	iner 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			h	4c. County of Death			
	Šį į		Southern Maryland Hospital				Clinton			1		rince Ge	
	Funeral					s. last birthday) Yrs.  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			(Month, E	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)			
ľ	Director		247-82-1 Usual Residence o	/851			110.			Nov.	11, 1	944 Sout	ch Carolina
	land ow		10a. State	10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Mary Fred i	į	D.C.			Wasi	hingto	n					1 X Yes 2 □ No
	or 28g	irec	10e. Street and Nu	mber				10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	th wil	Funeral Director	415 Varnu	um Street	, N.W.			2001	L		U.S		
	r dea ems er mu	ne	11. Marital Status 12. Was Decedent Armed Forces?		Ever in U.S. 13. Was		Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	10-	<ol> <li>Race - Ameri Black, White,</li> </ol>		
0	s afte	by Fi	1 ☐ Never Mari	ried 2 Married	1 ☐ Yes 2 🕅 l If Yes, Give Year or Dates:	√o 1 ☐ Yes		1 ☐ Yes 2 🌠 No	Specify:		Specify: Black		ack
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<u></u>	2 sho and I is ma auma	ı. I	19a. Informant's N	ame/Relationship	Type. Print)			ng Address (Street					p Code)
≥,	and sealth m 27				Daughter)	Tool 5		Box 816		ee, SC 2			5.4
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	t. Pa tmen tant: ijury			5 ☐ Other (Speci		Cro		ds Cemete		27/08		ters, SC	
פ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of H	uneral Service Lice	risee			2. Name and Addre					556
			23a, Part1, Enter	the disease, or com	polications that caused	the death		04 North				e, sc 29	Approximate
	nu fili		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Advanced end stay accounted immuno death. Synchronized and the condition resulting in death.										
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וומו	clan: ertific ector,	Be (	25. Was case refe examiner?	rred to medical				I au		ath (Check onl	nly one)		
5	Physic this c	To	1 ☐ Yes 2 ☐ 27. Manner of Dea	`	Hospital: 1 ☑ Inpatie		ER/Outpatie	all OLI DOX				6 □Other (Spec	ify)
	ding I	ion:	1 Natural	5 □Pending investigatio	(Month, Da	iy Year)	Injury		c. Injury at Work? 1 ☐ Yes 2 ☐ No		e now inju	w injury occurred	
15101	Attendeath death ctor:	licat	2 ☐ Accident 3 ☐ Suicide	6 Could not be	e 28e. Place of inj	ury - At ho	me, farm, st	treet, factory, office			28f. Location (Street and Number or Rural Route Number,		
2	To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Certification:	4  Homicide	determined	building, et	tc. (Specif	y)			City or 1	Town, Stat	e)	
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	Registr		MA	R 2 5 200	18 Septe	, K	Aps	de l'					
							Et. 10						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARCH 14, **GROVER WILSON COLLINS** 2008 2:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CESCENT CITY CENTER RIVERDALE if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1**XX**M 2□ F Yrs. Director 578.09.6828 93 SEPT 25, 1914 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits YYes 2 No Director CANDLER **PULASKI** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? **GREEN ST** 30451 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify þ 3 ☐ Widowed 4 ☐ Divorced Specify. WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALESMAN **INSURANCE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ MAGGIE HIGHSMITH ANDREW WILSON COLLINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 WESTCHESTER PARK DR UNIT 1810 COLLEGE PARK, MD 20740 HARJORIE ANN COLLINS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 XXRemoval from State METTER, CA LAKE GENETERY 3.30.2003 4 Donation 5 Dother (Specify) of uneral Service Lice 21. Signatur 22. Name and Address of Facility FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT K. CRECORY FUT 426 CRAIN HWY S. GLEN BURNIE, MD 21061 M01148 . Enter the disease k, r heart failu e. Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. 23a. Part1 Immediate Cause (Final disease or condition resulting in death) tears **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: funeral neral Director: A within 24 hours a

Be ٩ Certification:

Medical

State

Registrar

25. Was case referred to medical 1 ☐ Yes 2 No

27. Manne Death 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

29a. Certifier (Check only one) 29b. Signature and title of certifier

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

mo

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

0104

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of peath (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month, Day, Year)

5 2008 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

and manner stated.

08-01994 Robe

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 09386

bert A. Coleman		State of Maryland / D	Certificate	of Death	ai riygioni	Reg. No.		
	Re	- intent	Certificate	, Dodin	2. Oate	of Oeath	Year	3. Time of Oeath
hysician/		Oecedent's Name (First, Middle,Last)			Month Marc	h 11, 2008		0945 hrs
el xamine	4	Robert A. Coleman  Facility Name (if not institution, give street and number)		4b. City, Town, or Location of		40	. County of Oea	ath
	46	342 Bloom Street Apt. 407		Baltimore			N/A	Di II - I / Chato na
5	5	Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	If Under 1 Year If Under	Min		For	Birthplace (State or eign
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any		Da. State 10b. County 10	c. City, Town or Loc	cation				1 X Yes 2 No
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Aaryland 28a-f show 1 at once.	5 -	Md . N/A  De. Street and Number		10f. Zip Code		10g. Cit	izen of What C	ountry?
th the Maryland 23a or 28a-f sho notified at once.	ě			21216		US		
r death with the or items 23a or must be notif		2903 Presbury Street  1. Marital Status 12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	gin? ( Specify Ye	es or No-	14. Race - An White, etc	nerican Indian, Black, c.
ath w	<u> </u>	Armed Forces?	No			010.7		Black
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hin 7 hin 7 than	ompleted	12	Cus	todian	r's Name (First,	Middle Maide	n Surname)	бувсеш
od wil	ड़े	7. Father's Name (First, Middle, Last)				nuel		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Media	اچ	Robert S. Coleman	Jack Ma	Lau1	mber or Rural R	oute Number,	City or Town, S	State, Zip Code)
21 ould out d Mer	유	Iga. Informant's Name/Relationship (Type, Print )	190. Ma	Manse Cour	t-Balt	imore	Md.	21217
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Midical Examiner must be notified at one.	L	Jacklin Wilder	20h Place of Oi	sposition (Name of cemetery,	Oate	20	c. Location - Ci	ty or Town, State
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altir mit. partm porta ury o		71. Signature of Funeral Service Ligensee		22 Name and Address of Each	ërs Fu	neral Balti	servi more.	Md. 21217
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rsician	T	232 Part I. Enter the disease, or complications that caused t failure. List only one cause on each line.	ne seath. Uo not er	iter the mode of dying, seek es				Between Onset an Oeath
, wledical	ļ	Immediate Cause (Final disease a. Lung Cancer						
Examiner		or condition resulting in death)  Oue to (or as a conse	quence of):					
		Sequentially list conditions, if any leading to immediate b.  Oue to (or as a conse	equence of):					
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Divi spital or tours afte neral Dir	5	4 Homicide	mukaowiedae deat	th occurred at the time, date and	d place, and due	e to the cause	(s) and manner	r as stated.
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier Certifying Physician: To the best of raches only one)  2 Medical Examiner: On the basis of example states	amination and/or in	vestigation, in my opinion, deat	h occurred at th	e time, date a		
To th withir compl	Medical	and marrier states	d	29c. License num			29d. Oate sign	ieu (Montin, Day, rear)
	Σ	29b. Signature and title of certifier	7/	O.C.M.E.			March 12,	2008
		YNVI.						
1.		30. Name and address of person who completed cause of	f death (Item 23a)  Evaminer 11	11 Penn Street, Baltimo	re, MD 2120	01		
Q		Jack Titus MD. Deputy Chief Medical	rar's Signature	Land 1				
	Stat	## 9 5 2008 Links	rars Signature	yparen				AAAAP
Regi	stra	MAR 2 5 2000 Assess						OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6=07 AM MARCH 3008 /Medical Charles F. Chilcoat 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Raltimore
ri Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Union Memorial Hospital N/A

9. Birthplace (State or Foreign Country) If Under Age (In yrs. last birthday) **Funeral** Months M 2□F 50 Director 220-72-3304 14, 1957 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Maryland N/A Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3454 Hickory Avenue 21211 USA hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1√2 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: b 3 ☐ Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Meone. None Elementary/Secondary (0-12) College (1-4or 5+) None-Disability Disability 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George R. Chilcoat, Sr. Romayne B. Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Chalk Brother-in-law 1143 NW 131st Avenue, Pembroke Pines, Florida 33028 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 3/24/2008 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PUEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) ☐ Yes 2☐ No Ö 9 Unknown signed by t مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1∐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 No 1 Umpatient P 2 ER/Outpatient 3 DOA this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

State Registrar 29b. Signature and title of certifier

MAR 2 5 2008

MIRA HOHAMMED SIYAM, M.D., UNION MEMORIAL HOSPITAL, BALTIMORE, HD

31. Date filed (Month, Day, Year)

Registrar's Signature

29c. License number

AT 24389 46

29d. Date signed (Month, Day, Year)

and manner stated.

. Registrar's Signature

DAMIRA MOMMMHED SIYAM, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Alberta Cavey March 21, 2008 11:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Ye Genesis Eldercare Anne Arundel Severna Park If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year 1 □ M 2 🔀 F 96 216-60-5910 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Brooklyn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 523 Old Riverside Road 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: <u>}</u> 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Benson Annie Stewart 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Ms. Patricia Cavey/ Daughter 523 Old Riverside Road Brooklyn MD 21225 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o once. March 26, 1 XBurial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Brooklyn Pak, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 311 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-tran burial-trai Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 🗌 No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of D 39036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Chester Mil 2/6/9 8 2108 1/ Joseph 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

2008

DHMH 17 Rev 1/2001

State Registrar 900CATON

AVE BALTIMORE, MO2129

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0630 M Robert I. Dyer March 18 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Agnes Hospital Daltimore 5. Social Security Number Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country) March 29,1918 Indiana 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min 12 M 2□ F 306-18-9844 89 Director Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits a or 28a-f show be notified at 28a-f show 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane ST318 21228 ral", or Items 23a Examiner must b USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 (25 Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner any Injury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Rubber Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ivan Dyer Louise Barndollar 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beatrice Dyer Wife 717 Maiden Choice Lane ST318; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Park East 3/24/2008 Indianapolis, Indiana 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Septicemia disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner pheumonio Sequentially list conditions, if any, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nding physician and use as the burial-transit Due to (ocus a consequence of): Heart Box 68760, pe Fibr Physician/Medical tria latic use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached f 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ★No 24a Was an has page 2 After this certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident the Director; 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD P20556 20

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Registrar

31. Date filed (Month, Day, Year) 2008

Isbeth

St lovet. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 18 2008

Hosp. Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Time of Death Day Douglass Year 5:20 PM **Physician** lerbert March 20, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hopkins Bayview Care Center Baltimore Ci If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 86 1921 Maryland Nov. Director 214-14-1561 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number death with 1504 Pattison Road 21221 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after of Hygiene.

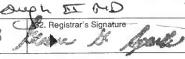
al Hygiene...

other than "natural", or iter 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: by Specify: WWII White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Inspector U.S. Customs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental is marked Rudolph Douglass Theresa Fogel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Leona Rita Douglass (Wife) 1504 Pattison Rd., Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 26, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Baltimore NationalCem 2008 Baltimore, Maryland 21. Signature of Euneral Service License Bruzdzinski Funeral Home, P.A. 1407 Old Fastern Avenue, Essex, Mar<u>yland 2122</u>1 Part1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Imme ate Cause (Final disea r.condition resulting in death) arr MINUTES **Physician** /Medical Due to (or as a consequence of) Examiner enal tai Sequentially list conditions, if any, Isaan g to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? depend performe Congestive 1 ☐ Yes 2 ⊡ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending .dspital ... .4 hours after dea.. ~ral Director: Affe Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 2008

27 State

1. Date filed (Month, Day, Year)
MAR 2 5 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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		1 - State Registrar Certificate of Death						8 09392	
Physician /Medical		1. Decedent's Name (First, Middle, Last)  Eugene Norwood Dever	2. Date of Death March	200	3. Time of Death 7:18 р м				
Examin	August .	4a. Facility Name (If not institution, give street and number)  Northwest Hospital Center  4b. City, Town, or Location of Death Randallstown  4c. County of Death Randallstown							
Funeral Director		5. Social Security Number 6. Sex 1	rs. last birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year 9 1928 N	. Birthplace <i>(State or Foreign</i> <i>County)</i> laryIand	
pund.		Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits	
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the N 28a-	rect	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	at Country?	
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ems 2	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, White, etc.	
should be filed within 72 hours after death with the Maryland and Mental Hyglene. In Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ξ	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes 2 ☐ No		1□Yes 2MŽNo	Specify:	,		White	
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filed v Hygie ther t	ပ္သ	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	faiden Surname)		
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shou and M s mar umat	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or Rura	l Route Number,	City or Town, Sta	ate, Zip Code)	
and 2 salth a		Robert J. Devers - son			llburg Rd		<del> </del>		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	o. Place of Dispo- cemetery, crem Vergreen	sition (Name of natory or other place Mem. Gal	e) !	i	20c. Location - Cit 208 Finks	ty or Town, State	
permit. Departr Importa any inj		21. Signature of Fuperal Service Licensee						napel P.A. s, MD. 21117	
Physician		23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.			g, such as cardiac o	*		Approximate Interval Between Onset and Death	
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or the Hospital or Attending Physician: The law requires that the death certifications after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month		
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.		vestigation, in my o	pinion, death occur	red at the time, d	ate and place, an	d due to the cause(s)	
To To con	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  3/20/2008							
12+1		30. Name and address of person who completed cause of death (I			S SUITE	209	WESMIN	STER MA	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6.30 AM 2008 march MICHAEL HUGH EDWARDS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner baltimore 7. Age (In yrs. last birthday) On Hospidal 1 Dinas If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral X** M 2□ F Days Months Hours Min Yrs. Director FLORIDA APR. 19, 1985 595.32.2658 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2√√No Director DADE CUTLER BAY FI 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code a or ms 23a 10210 HAITIAN DR. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item: edical Examiner n Black, White, etc. XX Never Married 2 ☐ Married 5-0036 1 ☐ Yes 2 ☐ No Specify Specify: WHITE Completed by 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MANAGER RESTAURANT 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be ပ VALERIE ESPLIN EDWARDS MICHAEL HUGH EDWARDS SR 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE EDWARDS MOTHER 19701 SW 110 CT. APT. 829, CUTLER BAY, FL 33157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ţ 1 ☐ Burial 2√C Cremation 3 ☐ Removal from State Ξ ò Important: 4 □ Donation 5 □ Other (Specify) BAYVIEW CREMATORY INC. BALTIMORE, MD MAR. 25, 2008 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee GREGORY <del>1401148</del> 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Mostrole equence ): /Medical Due to (or as a consequence Examiner Copila tory if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner Due to (or as a consequence of) sician a burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ 2 Fetal death 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 3 Probably 4 □Unknown 1 ∏Yes 2 ∏No 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □Vo 24a. Was an has page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Collisan Hospital or Attending Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2-22-2008 1800 Driver of auto-tixed object. 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Southboard ) wings Hill

State Registrar

Medical

(Check only

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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and manner stated.

MD 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

3316

Hopital

29d. Date signed (Month, Day, Year)

MARCH, ZZ, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4 per md 9 per th 877 3-25-08 vt. Certificate of Death 1. Decedent's Name (First, Middle, Last) Date o. Month 3 2. Date of Death Day 9 2008 **Physician** ero Ewell 7:50 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3800 West Belvedere Avenue Baltimore Baltmore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number Age (In yrs. last birthday) **Funeral** Days 1 ■ M 2 🗹 F 218-09-9405 0 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No N/A **Baltimore** Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 West Belvedere Avenue 21215 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO þ Specify Specify Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pennsylvania Railroad Porter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amelia Ewell Edward Ewell ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 West Belvedere Avenue Baltimore, Maryland 21215 Barbara Bailey 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ pcremation 3 ☐ Removal from State Catonsville, Maryland 03/15/08 4 Donation 5 Dother (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
U2 Weeks Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Asmahan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Jivision or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown cate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ severe Fibrillation 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed assiration 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes No 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours : To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062920 ause of death (Item 23a) (Type, Print) Zamona neni 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

		For State	State of Ma	aryland / Dep	oartment of Fertificate of		, ,	000	0 00005
	-	Registrar  1. Decedent's Name (First, Middle,	l ast)		erinicate or	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
Physici		Lacy W. E				24, Day 2008 Ye			
/Medi Examir		4a. Facility Name (If not institution,	,			or Location of Death	4c. County of E		
	8	Vindobona Nurs				lock Heigh			ederick
Funeral Director		230-54-7637	3.7	e (In yrs. last birthda 62 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 03/28/	y Year)	Birthplace (State or Foreign Country) irginia
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
Maryla f sho ied at	ō	MD Washi	ngton	Hage	erstown				14 Yes 2 □ No
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
th with	a D	128 E. Franklin	Street		21740	)		United St	ates
Ind 21215-0036  be filled within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? d 1 Tyes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	8. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:	American Indian, White, etc. White
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "natural"; or myn Injury or other traumatic event, the Medical Examinance.	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	edent's Usual Occup	pation during most of work	ina I	16b. Kind of Busine	ess/Industry
Mithin han "	mple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	DO NOT use retire Painter	during most of work	9	Constru	ation
Ind 21 be filed w ital Hygie d other ti event, tib		17. Father's Name (First, Middle, Li	ast)		atticet	18. Mother's Name	e (First, Middle.	Maiden Surname)	CCIOII
Iryland 2 should be filed nd Mental Hygi marked other imatic event, i	o Be	Sam Nick Edwar						anning	
Maryla d 2 should th and Men 7 is marke traumatic	ပို	19a. Informant's Name/Relationshi		19b. Ma	iling Address (Street	t and Number or Run			te, Zip Code)
e, Mc		Monica Edwards,	Daughter	132	S. Mulber	ry Street	, Hager	stown, MD	21740
of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	Removel from State	20b. Place of Dis	position (Name of rematory or other pla		Date	20c. Location - City	y or Town, State
Pages ment of lant: If its		4 □ Donation 5 □ Other (Spe	ecify)	Medcure		i		Portland	·
Baltimore, IN permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.		21. Signature of Funeral Service Li	Harris	I		ess of Facility Ha			•
		23a Part1 Enter the sease or o		M01113		burn Driv			MD 21061 Approximate
Physician		23a. Part1. Enter the lasease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Lung CANCW T metasis  YCALS							
/Medical		disease or condition resulting in death)		a consequence of):	o men	W)13			TUMES
Examiner		Conventielly list conditions	h			_			
Po 4 to	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
cate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
8760, rate be ex chysician a		,							
687 ficate phys	edical	d							
Hecords, P.O. Box 6  The law requires that the death certific the has been signed by the attending p  age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death	B □Ectopic pregnanc i □ Other (specify) _	су		23d. Date of Month	
that the hold by detail		Part II. Other significant condition	4 1		underlying cause giv	ven in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
rds quires en sign	ed by	Covonary 1	sease				Yes 2 No 3 Probably 4 Unknown		
Vital Records, sician: The law requires the certificate has been signer rector, page 2 should be d	Completed						24a. Was	an 24b. Wer	re autopsy findings available r to completion of cause of
	E O						perfo 1∐ Yes	rmed?   dea	th? Yes 2 No
Vital Rec sician: The law s certificate has to lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		O#	26. Place of Deat	h (Check only o	ne)	
Or Physical this call direct	2	1 Yes No 27, Manner of Death	1 ☐ Inpatie		ent 3 DOA			dence 6 Other (	(Specify)
Onding ding h. After fune	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Da	y Year) Injun	Wo	rk? ]Yes 2∐No	Zod. Dodolibe i	iow injury occurred	
DIVISION Or VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, c. (Specify)			28f. Location (S City or Tov		or Rural Route Number,
Hospite 4 hours Funera ely fille	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
o the thin 2 the o the σ the σ the	Med	29b. Signature and title of certified	and manner st	ated.	29c. Licens	se number		29d. Date signed (A	Month, Day, Year)
F 3 F 8		A	W		Doc	62113			
2		30. Name and address of person w	hd completed cause of d	eath (Item 23a) (Typ	e, Print)	-		-14[,	
~		//	LORUM, MI	0 11987	J DHUE	FREDER	ick, o	10 21762	
Sta Regist		31. Date filed (Month, Day, Year) MAR 2 5	2008 32. Sistr	ar's Sig <del>nature</del>	hour				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-02107 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 Cathy Louise Funk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day March 15, 2008 **Medical Examiner** Cathy Louise Funk 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester 205 Talbot Street Ocean City If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 

Director		195-46-3490 1□M 2×F 52 Yr	S. Months Days Hours Min.	July 27, 1955	Country)				
апу		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Ir							
<u> </u>					1 X Yes 2 No				
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of	What Country?				
ith the Maryland 23a or 28a-f sho		205 Talbot Street	21842	i	JSA				
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Manel Hygiewill the Maryland tem 27 is marked other than "matural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- 14. Ra	ace - American Indian, Black, hite, etc.				
or ite	Funeral	1 Yes 2 No							
urafte	à	3 Widowed 4 Divorced If Yes, Give Year or Dates  15. Decedent's Education (Specify only highest grade completed) 16a. Decede	Yes 2 No specify: ent's Usual Occupation (Give kind of work		y: White Business/Industry				
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retired)		-				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Completed		House Keeper	rst, Middle, Maiden Surnar	ospitality				
15-0 filed w d othe		17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surnar					
2121 2121 ould be fi Mental marked	To Be	Robert L. Funk  19a. Informant's Name/Relationship (Type, Print)  19b. Mailli	ng Address (Street and Number or Rura						
MD 2 d 2 shou lth and N n 27 is n			o West Adkins Ave.	Willards, N	ID 21874				
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than 'njury or other traumatic event, the Medical		20a. Method of Disposition 20b. Place of Dispo	osition (Name of cemetery, Da	ate 20c. Locatio	on - City or Town, State				
				19,2008 Ha	Lnover, MD				
Baltin permit. I Departm Importa injury o		21. Signature of Funers: Service Lice s 22.	G: fts Registry March Name and Address of Facility Anato	iny Gifts Reg	istry				
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	522 Connelley Drive	Suite P. Ho	enover, MD ZIOTLO				
Physician /Medical		falure. List only one cause on each line.		ory arrest, SHOCK, OF	Between Onset and Death				
∵xaminer		Immediate Cause (Final disease or condition resulting in death)  a three conditions are consequence of:	rular disas						
		Sequentially list conditions, b							
	ine	if any, leading to immediate  Due to (or as a consequence of):							
, p .#	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
xecute rans		d	7 3/26/08 amh						
760, cate be execut physician and	sician/Medical	AMENDED AMENDED 23, 27 per 1715 go7  IF FEMALE: 23c. If yes, outcome of pregnancy	. 0, 20, 00 tuit	23d Date	e of delivery				
3876 rtificat ing ph. as the	an/N	23b. Was decedent pregnant in the 1 Live birth 2 F	etal death 3 Ectopic pregnancy						
Box 68760, no death certificate be the attending physical reference of for use as the burned for use as the burner and for	sici		Other (Specify)						
Ç € £ 5 €	F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death?				
, P.O.	্র			1 Yes 2 No	3 Probably 4 Unknown				
ords, aw require as been si	pleted			autopsy	b. Were autopsy findings available prior to completion of cause of				
eco he law tte has ige 2 sl	Comp		-	performed? 1 ✓ Yes 2 No	death?				
'ital Recor sician: The law is certificate has b irector, page 2 sh	Be Co	25. Was case referred to medical	26.Place of Death (Check only	y one)					
> 출 결합	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien			6 Other: Scene				
n of ding Pl h. After funeral	ä	27. Manner of Death 1 XX Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	f Injury 28c. Injury at Work? 28i	d. Describe how injury occ	currea				
Sion Attentry death ector:	cati	2 Accident Investigation 28e Place of Injury - At home farm str		f. Location (Street and Nu	ımber or Rural Route Number, City				
Div ital or ital or ital or led in l	Certification:	3 Suicide 6 Could not be determined (Specify)  Suicide 6 Could not be determined (Specify)							
Hospi 24 hou Fuuer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place, and due	e to the cause(s) and man	nner as stated.				
Division To the Hospital or Attent within 24 hours after death To the Fuueral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	ation, in my opinion, death occurred at the	e time, date and place, ar	nd due to the cause(s)				
. > - 0	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		signed (Month, Day, Year)				
,	D2000 1 01/10 10 10								
K		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 2	21201					
	tate	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	The state participation of the state of the						
Regis	35.10	MAR 2 5 2008 Bear &	HE!						
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3. Time of Death

1825 hrs

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Day MARTIN MARCH 2008 AM **FULLER** 23 9:51 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 401 YESHIVA LANE, APT. BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country)
 MEXICO 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months 42 11/09/1965 591-98-4507 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No MD BALTIMORE Director BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 401 YESHIVA LANE, APT. 3D 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical d 2 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) **TEACHER** EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **FULLER HERSZ** MARTHA SCHACK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHAYA MIRIAM FULLER / WIFE Important: If item 27 is any Injury or other traconce, 401 YESHIVA LANE, APT. 3D, BALTIMORE, MD 21208 permit. Pages 1 and 3 Department of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State HAR HAMNUCHOT 03/24/2008 JERUSALEM, ISRAEL 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Respiratory 2 MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG CANCEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conscriuence off. Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Year 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 100 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has e 2 autopsy page death? certificate 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day 28b. Time of funeral 27. Manner of Dath 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check or one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie an 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) Suith Ave BALTIMERS JAKOB 32. Pegistrar's Signatura 2835 31. Date filed (Month, Day, Year) State Registrar

**Funeral** 

Director

**Physician** /Medical Examiner

The law requires that the death certificate be executed g / ed by the attending physician detached for use as the buria page 2 should Physician: director, this completely filled in by the funeral within 24 hours after death. To the Funeral Director: After To the Hospital or Attending

Division or Vital Records, P.O. Box 68760,

D State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year BERNADETTE 09:30 PM MARIE 19 2008 March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HARBOR HOSPITAL BALTIMOR N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y)
Apr. 27, 5. Social Security Number Year Days 1 □ M 2 🗗 F 218-26-5555 75 1932 Apr. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4500 Poplar AVenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify.White Be Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Solo Cup Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo McNulty Alice Margaret Baker ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Adams - Daughter 4006 Belle of Georgia, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 3-24-2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Serv 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 e ps is Due to (or s a consequence of): Urinary tract infection - Protects bucteresia Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 □Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pancreatitis 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Acute renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 🔼 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Harover St, Baltimore, MD, 21225 ARTURO LOAIZA-BONILLA 3 Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 5 2008

DHMH 17 Rev 1/2001

Physician /Medical Examiner

**Funeral** Director

Please	State of Mar				-		00000
1 - For State Registrar	State of Ivial		rtificate of			. No.	03393
Decedent's Name (First, Middle, Last					Date of Death     Month	Day Year	3. Time of Death
Virginia Kloess	Gordon				March 17		3:00 A M
4a. Facility Name (If not institution, give Asbury Methodist				r Location of Death		4c. County of Dea	
5. Social Security Number 6. Se		(In yrs. last birthday)	Gaither If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgome 9. Bir	tholace (State or Foreign
	¬ 7-7-	8 Yrs.	Months Days	Hours Min.	Sept. 16	, 1919 Ne	w York
10a. State 10b. County		IOc. City, Town or Lo	ocation				10d. Inside City Limits
Maryland Montgome	ry	Gaithers	burg				1 X Yes 2 ☐ No
10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
333 Russell Avenue			20877			.S.A.	
11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
3 ₩idowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business	
(Specify only highest grade Elementary/Secondary (0-12)	le completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ing		,
12			emaker			Own Hom	e
17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)	
Theodore Kloess				Margaret	Cramden		
19a. Informant's Name/Relationship (T)				and Number or Rura			
	Daughter)	the same and the s	The state of the s	Elm Dr., (			
20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☒ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, crer Life Ques	natory or other plac	ce)		c. Location - City or Allentown	
21. Signature of Funeral Service Licens				ss of Facility The Anatomi			
X penin (2/2	Mun			Ler St., V		1. PA 180	52
23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	lications that caused th	ne death. Do not ent					Approximate Interval Between
Immediate Cause (Final disease or condition	Canon	281-11	artes	ude	seas		Onset and Death
resulting in death)	Due to (or as a	consequence of):					7
Sequentially list conditions	b						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
	Due to (or as a t	consequence on.					
	d						
IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of de	livon
23b. Was decedent pregnant in the past 12 mg/hths?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)	,		Month Month	Day Year
9 Unknown	9□ Unknown						
Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
myestive	heart	arless	, huje	rtenses	n 1 □ Yes	2 12 No 3 P	robably 4 Unknown
Hypathipa	idum,	treas	take	cuma	24a. Was an	24b. Were a	utopsy findings available completion of cause of
Alsheimod	dem	Itia 1	mater	11111	autopsy performe	d? death?	
25. Was case referred to medical examiner?	, , , , ,	) =	The contract of	26. Place of Death	(Check only one)	1100	- 20,10
1 Yes 2 No	lospital: 1 ☐ Inpatient	2 ER/Outpatien	nt 3 DOA Oth	er: 4 12 Nursing Ho	me 5 Residenc	e 6 ☐Other (Spe	icify)
27. Manner of Death  1 2 Natural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe how	injury occurred	
2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
(Check only 2   Medical Exami	sician: To the best of e	xamination and/or in:	n occurred at the tir	ne, date and place, pinion, death occurr	and due to the caus	se(s) and manner as	s stated.
one) 29b. Signature and title of certifier	and manner state	d.	29c. Licens				
250. Signature and title of certifier	<u>د</u>	, 0	Zac. Licens		ļ.	. Date signed (Moni	
30. Name and address of person who co	ompleted cause of dea	th (Item 23a) Type.	Print)	4-115	110	18/1/10°	12000
H. ROBERT B.	RSCHBA	Helt, MI	1. 2	AITHER	SBURG,	renué MAZO	877
31. Date filed (Month, Day, Year)	32 negistrar's	s Signature	alle 1		/		
MAR 2 5 200	O Littleson	July Sugar	September 1				

DHMH 17 Rev 1/2001

State

Registrar

MAR 2 5 2008

		rotified at notified at
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Hoelih and Montel Hudiana	Importants to meant a managed than "natural", or items 23a or 28a-f show important: If item Z7 is marked other than "natural", or item Z7 is most be notified at any injury or other traumatic event, the Medical Examiner must be notified at
Baltimore	permit, Pages 1 (	Important: If item any injury or other

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar			Cei	tificate (	of Death	1	Re	g. No.2	JUB	094				
ioion	1. Decedent's Name (First, Middle	le, Last)					1	2. Date of Deatl Month	n Day	Year	3. Time of D				
ician dical	BEATRICE	GRAY						03		2008	06:30				
niner	4a. Facility Name (If not institutio		nber)			n, or Location			4c. Count	ty of Death					
	University of	Herrland				Baltim									
ai	5. Social Security Number	6. Sex 1 □ M 2 💢 F	7. Age (In yrs. I 78	last birthday) Yrs.	If Under 1 Y Months Da	ear If Under ays Hours	Min.	3. Date of Birth (Month, Day,	Year)	9. Birthi	place (State or F ntry)				
or	215-36-5188 Usual Residence of Decedent		70					lept 19,	1929						
	10a. State 10b. County	,	10c. City	, Town or Lo	cation						10d. Inside City				
ō	MD Dorc	hester		Cambri	dge						1 □ Yes 2				
<u>s</u>	10e. Street and Number				10f. Zip Co	de		10	g. Citizen of	What Cou	ntry?				
O C	22 Meteor Aven	ue #104				21613			Į	JSA					
Funeral Director	11. Marital Status u	nk   12. Was Dece	dent Ever in U.		Vas Decedent	of Hispanic Or Cuban, Mexica	rigin? (Spec	ify Yes or No-		ace - Americack, White,					
	1 ☐ Never Married 2 ☐ Mar	ried 1 ☐ Yes If Yes, Give	2X No		ı □ Yes 2 <mark>X</mark>			iodii, otoi,		<sub>ify:</sub> whi					
d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	tes:												
Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give		one during mo:	st of working	unk	6b. Kind of	Business/In	dustry				
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	unk 17. Father's Name (First, Middle,	unk			unk	18 Moth	or's Name	First, Middle, N	faidan Surna	oma)	u				
Be	17. Tallier 5 Name () 1131, Imagie,	, Lasty			unk	10. 110.11	ici a rianic (	r not, middio, ii	underr Garria	iney					
유	19a. Informant's Name/Relations	ship (Time Print)		19h Mailin	n Addrage (St	reat and Numb	or or Bural	Route Number,	City or Town	n Stata Zir	n Cada)				
	University of		1					ltimore		2120					
1. 2.	20a. Method of Disposition	IID HOOPIG	20b. P	lace of Dispo	sition (Name o	of .	Da		20c. Location	- City or T	own, State				
	1 Burial 2 Cremation		state	emetery, crer	natory or other	r place)				-					
الم	4 □ Donation 5 🛣 Other S		/ Le	22	Name and A	ddress of Facil	lity								
ouce	21. Signature of Euneral Service Ronald	S. Wade, D	irector	I		_		655 W.	Balti	imore	Street				
	23a, P.vili. Enter the disease, o	r mplic til vis that ca	used the death			re, MD dying, such as			est.		Approximate				
	1/200	sh con heart failure. List only one cause on each line. Interval Between Onset and Death disease or condition a. Sepsis													
n al	Immediate Cause (Final disease or condition resulting in death)  a. Se psis  Due to (or as a consequence of):														
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	resulting in death) Last	Due to (d	or as a consequ	uence of):											
ical															
Medical	IF FEMALE:														
	23b. Was decedent pregnant	23c. If yes, outo	come pf pregna rth 2 ☐ Fetal	ncy Ideath 3	Ectopic pregn	ancy				ate of deliv	•				
Sici	in the past 12 months? 1 ☐ Yes 2 🗷 No		ant at time of de		Other (specif				iv	<b>fonth</b>	Day Ye				
Physiciar	9 ☐ Unknown Part II. Other significant conditi			Uting in the	adarkija a aar	n divers la De 1		220 Did +-	2000 1120 55	ntributo to 1	the cause of dea				
þ	Part II. Other significant conditi	ions contributing to de	atn but not rest	ulting in the ur	nderlying cause	e given in Part	1.								
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lple								24a. Was ar autops	y .	prior to co	opsy findings av ompletion of cau				
ပ်								perförn 1□ Yes 2	neg?	death? 1 ☐ Yes	2□ No				
Be	25. Was case referred to medica examiner?	Hospital:			1		e of Death	(Check only one	)						
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Certification:	1 Matural 5 ☐ Pendi	ng (Monti	h, Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐		3d. Describe ho	w injury occi	uned					
icat	3 Suicide 6 Could		of injury - At ho	me farm str				of Location (St	root and Num	nher or Rus	al Route Numbe				
₹	4 ☐ Homicide determ	nined buildir	ng, etc. (Specify	/)	,		20	City or Town		Joi oi nul	a. Floate Nutrible				
- T	29a. Certifier 1 Certifyi	ng Physician: To the	best of my know	wledge, death	1 Occurred at the	ne time, date a	ind place a	nd due to the co	ause(s) and r	manner as	stated				
	Service Service (III)	I Examiner: On the ba													
	(Check only 2 ☐ Medical one)	and mann			000 1:	cense number		20	d. Date sign	ned (Month	Day Year)				
Medical Cer					29C. LR	sense number			di Date oigi	ied (interior)	, _ a, , a,				
	one)	er													
	one)	<b>91.0</b> .	of death (Item	23a) (Tvpe.	a	27206				1/2008					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Mary	yland /				lealth a Death	and Me	ental H	ygiene Reg. No	7111	18	0941	0
	ysicia		Decedent's Name (First, Min     Mary		Ann		Gib	bs				1	2. Date of D Month larch	Death	y 2008	ear	3. Time of Dea 6:10I	
	Medic camin		4a. Facility Name (If not institu	tion, give	street and n	umber)			4b. City	/, Town, or	Location o	f Death		4c	. County of	Death	1	
	esc		604 Minnerva			7 4 //	t4 t-	landle alexa.			urnie	04 Uzo	0 D-44 F		Anne A			
	eral ector		5. Social Security Number 212–26–7549	6. Se	х ] M 2[ <b>X</b> F	7. Age (I	n yrs. last b	Yrs.	Months		Hours	Min.	8. Date of E (Month, I Feb.1	3, 19.	31	Cour	lace (State or Foi htry) MD	reign
land	44		Usual Residence of Decedent  10a. State 10b. Cour	nty		10	Oc. City, Tov	vn or Lo	cation			<u>-</u>				1	0d. Inside City Li	mits
Mary -f sho	lied a	tor	MD Anne	Arui	ide1		G1en	Bur	nie								1  Yes 2	No
th the	noti	Director	10e. Street and Number						10f. Z	ip Code				10g. Cit	tizen of Wha	at Cour	ntry?	
ath wil	ust b	ra L	604 Minnerva	Road					210	61				U.S	5.A.			
DaltilliOfe, Intaryliating ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show	aminer m	by Funeral	11. Marital Status  1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce		12. Was De Armed F 1 ☐ Yes If Yes, G Year or	Forces? 2 A No Bive	er in U.S.	1	Was Dec f Yes, sp 1 ☐ Yes	ecify Cuba	ispanic Orig n, Mexican Specify:	gin? (Spec i, Puerto F	cify Yes or Nican, etc.)	10-	14. Race - Black, Specify:	White,		
72 hour	lical E	eted t	15. Deced	lent's Edu	cation		168	a. Deced	dent's Us	ual Occupa	ation during most	t of workin	a	16b. K	ind of Busin	ness/Inc	dustry	
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d be filed antal Hygical medical control of the con	vent, t	Be C	17. Father's Name (First, Midd	lle, Last)								r's Name	(First, Midd					
yidi buld b Menta arked	atic e	은	August Ellis								De1ma	а Е.	Myers					
Vical 12 sho h and 7 Is m	traum		19a. Informant's Name/Relation Mrs. Delma Ph			000			_				Route Nun		or Town, St.	ate, Zip	Code)	
stand Healt Hem 2	other		20a. Method of Disposition				20b. Place o					pril			ocation - Ci	ty or To	own, State	
Page:	ury or		1 X Burial 2 □ Crematic 4 □ Donation 5 □ Other			n State	Arlin					prii 2008		Arl	ingto	n . V	4	
partification permit. Pages Department of Important: If It	any Inju		21. Signature of Funeral Serv	ice Licens	ee	/MO	1357							ı Fun	era1	& C:	remation MD 2106	
	\$ P		23a. Part1. The disease shock, or heart failure. I	or compl	ications that ne cause on	caused the		_				-			Durii	10,	Approximate Interval Between	1
Physic			Immediate Cause (Final disease or condition resulting in death)		a	he t	estav	Line	R	2009	1 (e	11 (	WCI	2000	10		Onset and Deat	h
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ertifica ling ph	e as th	Med	IF FEMALE:							140	Design			- 1		-		
death cer e attendir	d for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1	4□Preg	birth 2 D gnant at tim	Fetal deat		Ectopic Other (	pregnancy specify)					23d. Date of Month		ery Day Year	
at the	etache	Phys	9 🗌 Unknown		9□Unk		4	Ab	- d - ab da -		a to Bank I		OO - Die				ne cause of death	0
requires the	uld be d	ò	Part II. Other significant cond	intions co	minouting to	death but n	ot resulting	in the ur	denying	cause give	en in Part I.				`		ably 4 □Unkn	
law re	e 2 sho	Completed											24a. Wa	opsy	pric	or to co	psy findings avail mpletion of cause	able
The The icate h	r, page												1□ Yes	formed? 2,EIN		ath? ]Yes	2)XIN0	
s certii	irecto	Be	<ul><li>25. Was case referred to med examiner?</li><li>1 ☐ Yes 2 ☐ No</li></ul>	· -	lospital:	7 Inpatient	2 □ ER/O	utnation	+ 3□□	Othe			(Check only	/	6 □Other	/0	· .	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending	funera	tion: To	27. Manner of Death 1 Natural 5 □ Pen	ding stigation	28a. Date	e of Injury onth, Day Ye	28b.	Time of Injury		28c. Injury Work		28			ry occurred	` '	y)	
or Atter after dea Director	I in by the	Certification:	3 Suicide 6 ☐ Cou	ld not be ermined	28e. Plac buil	ce of injury ding, etc. (S	- At home, f Specify)	arm, stre	eet, facto	ry, office		28		(Street ai own, State		or Rura	al Route Number,	
To the Hospital or Attendituding 24 hours after death To the Funeral Director:	etely filled	Medical C	29a. Certifier 1 Certific (Check only one) 1 Medic	ying Phy cal Exami	sician: To the ner: On the and ma	ne best of m basis of ex	amination a	je, death nd/or inv	occurre vestigatio	d at the tin	ne, date and pinion, dea	d place, a th occurre	nd due to thed at the	ne cause(s e, date an	and manr d place, an	ner as s d due to	tated. the cause(s)	
To the To the	comp	Me	29b. Signature and title of cert	Mer		j-	2		2	9c. License	e number			29d. Da	ite signed (	Month,	Day, Year)	
			1/10	ng	1	Ant				0	7/5	1)		190	rch	24	1000	F
(	8		30. Name and address of pers	on who co	ompleted cau	use of death	h (Item 23a)	(Type, I	Print)	Ho	Soit	of 1	Dive	G	len B	מנא	1 M.Z.	106)
Re	Sta egistra		31. Date filed (Month, Day, Ye MAR 2	ar) 5 200		Registrar's	Signature	Sex	uli	į	6	,		)			, , , , , , , , , , , , , , , , , , , ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 2:45 AM Elliott Goodman March 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Easton Talbot Hospice Talbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 218-50-1988 58 August 19, 1948 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1, Yes 2 No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Parris JSA Lane 21601 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Oil Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert William Elliott Martha Councell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Goodman Parris Lane Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry March 19,2008 Hanover, MD 5 ☐ Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive suite P. Hanover, M.D. 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician vear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the SS attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 TYes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform certificate the Hospital or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Hospice Certification: To 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred hours after death. uneral Director: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion doubt accurred at the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Teal Drive

Suite 302

Easton MD 21601

who completed cause of death (Item 23a) (Type, Print)

-8221

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician **Physici** Day 4:40 PM Gryzlo Frank Marcin 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Johns Hopkins Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral №** M 2□ F Months Days Hours 160-16-3516 89 June20,1918Pennsylvania Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The 21s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County 10d Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑No Director Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1714 Brookview Road 21222-1206 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. δ Specify: 3 ₩ Widowed 4 Divorced White Hygiene. other than "natura ent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sparrows Point 12th Heat Treater 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Frank Gryzlo Mary Graybosh 19a. Informant's Name/Relationship (Type. PrinDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Smith 5127 Benton Height Ave. Baltimore, Md.21206 permit. Pages 1 an Department of Healt. Important: If item 27 any Injury 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3-21-2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitaczorowski Funeral Home, PA 23a. Part1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1201 Dundalk Ave. Baltimore, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 36 hours /Medical Due to (or as a consequence of): **Examiner** Urinary Tract days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Dav Year 5 ☐ Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 24a. Was an performe Insufficiency Renal Chronic 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 T Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera

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State

Registrar

Palaniappan Muthappan MD 31. Date filed (Month, Day, Year) MAR 2 5 32 Registrar's Signature

29b. Signature and title of certifier

and manner stated.

medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18140 Eastern Avenue

Doctor

29c. License number

RES -000

Baltimore

MD

29d, Date signed (Month, Dav. Year)

20

2008

March

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2:22PM M Helen Louise Geist March 18, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🛛 F May 2, 1921 86 MD 217-14-3306 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 82 Hanover Road 21136 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper MD Casualty Ins. Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Frantz Geist <u>Helen Marie Welsh</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Neal Haynie Friend 120 Lamport Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 3/22/08 Finksburg, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy 1□ Yes 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

δ

Completed

Be 2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at an one.

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

nding physician and use as the burial-transit atten for us signed by the a has page After this certific funeral director,

The law requires that the death certificate be executed

or Attending

Hospital

Division or Vital Records, P.O. Box 68760,

1 Natural

2 Accident 3 ☐ Suicide

4 THomicide

(Check only one)

29a, Certifier

27. Manner of Death 5 Pending investigation

6 Could not be determined

2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier um

51705

29d. Date signed (Month, Day, Year)

WD

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State

Registrar

within 24 hours after death.

To the Funeral Director; Af
completely filled in by the fur

PANSURIYA 31. Date filed (Month, Day, Year)

349 malwim 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Registrar

MAR 25

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Day Year GERTRUDE GROUPP mar. 21,2008 4:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE LEVINDALE N/A Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Months Days Hours 214-38-4700 93 Yrs. Director 01/03/1915 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits Hygiene. other than "natural", or items 23a or 28a-f shov ent, the Medical Examiner must be notified at MD BALTIMORE BALTIMORE Director 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1450 BEDFORD AVE., #131 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐ Yes 2 K∏ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON d 2 should be filed w h and Mental Hygiel 7 Is marked other th RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ELLIS** KAMINKOW ESTHER KORMAN Pages 1 and 2 should ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 Is any injury or other trau SHIRLEY RUBIN-ROLLINS/DAUGHTER 19 GLYNDON DRIVE, REISTERSTOWN, MD 20b. Place of Disposition (Name of ANSHE EMPINAL) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) AITZ CHAIM BALTIMORE, MD 03/23/2008 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Libense 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIOMYOPATITY Physician /Medical Due to (or as a consequence of): Examiner AORTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760€ Due to (or as a consequence of): attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 20063327 DURAW IT. WUTDEHINGT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIZAW WOLDEHINOTIMD 2434 W. BELVEDERE AVE, BILTIMORE, MD 21237 32 Registrar's Signature 31. Date filed (Month, Day, Year) ے State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after death • Funeral Director: within 24 horn To the Fune completely fi

State Registrar (Check only one)

29b. Signature and title

a Kisey 32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

900

29c. License number

29d. Date signed (Month, Day, Year)

sute 300 Anneolis, MO 214101

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 8:40 PM Augusta B. Green march 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital P.G. Lanham If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Yrs 578-22-7847 87 Director 12-22-1921 West point, MS Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1▼Yes 2□No Directo Md PG Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 13310 New Acadia Ln. #203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specif Black Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natui any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elzonia Graves 2 William Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 13310 New Acadia Ln. #203 Upper Marlboro, Md John L. Green/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State Lincoln\_Mem. Ceme. 3-25-08 suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Mem. Ceme. 3 20 7 Facility Ronald Taylor II Funeral HM 21. Si vature of Funeral Service Licensee 108 W. North Ave. Baltimore MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardio resp Immediate Cause (Final is atory Physician resulting in death) /Medical Due to (or as a consequence of): Examiner ahon Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1☐ Yes 2☐No 9☐Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ natrem 2XNo 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an page 2 s autopsy URINAY 25. Was case referred to medical examiner? Be ( funeral director 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1' Inpatient 2 ER/Outpatient 3 DOA 27. Manner of D th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, Hospital or Attending 24 hours after death • Funeral Director: completely

altimore, Maryland 21215-0036

filled in by

Registrar

31. Date filed (Month, Day, Year)

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

ALAFA

29a. Certifier

and manner stated.

GREENORLT

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

30%

Registrar's Signature

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20 **Physician** Holmes PM 011 al 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Normwest Hospital- seasons hospice Randallstown Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG 28 1942 7. Age (In yrs. last birthday) **Funeral** Days Maryland 219-38-4768 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Tyes 2 No Director MD Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21040 509 Arum Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1∐Yes 2**X**No Saltimore, Maryland 21215-0036 Specify Specify: Black þ 3 ☐ Widowed 4 K Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Commercial 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Charles Holmes Lila Hughes ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jacqueline Glascoe - Daughter 509 Arum Court, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/21/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Williams 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a pursuomence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 X No 24a. Was an certificate has t rector, page 2 s autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS PIC UNI Hospital: 은 2<sub>k</sub> No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1. Natural 5 Pending investigation 1 🗌 Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif

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State <sup>31.</sup> Registrar

31. Date filed (Month, Day, Year)
MAR 2 5 201



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Margaret Day Month Year **Physician** 15 March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REHAP Social Security Number If Under 24 Hrs. Date of Birth (Month, Day, last birthday **Funeral** Months Min. 215.12.479 1 □ M 2 🔭 Days Hours MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore MD Reisterstown 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Cherr 311 Road 21136 Chapel USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by American 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Magnes. College (1-4or 5+) ntary/Secondary (0-12) Domestic Housekeeper 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be N. osephine Walton <u>lonnson</u> ၉ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 Print) Drive Suite E Have Bridges Dauanter 201 Secretariat De Grace, MD Margaret 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from 22/08 Monkton, MD Union Chapel Cemeton 03 4 Donation 5 Dother (Specify) 22. Name and Addres Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licenses augh Road Randallstown MD 21133 1berty Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical quence of) **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregg 3 ☐Ectopic pregnancy Month in the past 12 mor 1 ☐ Yes 2 ☐ Yo Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of eause of death?

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29b. Signature and title of certifier 29c. License number 29d. Date signed ( <i>Montin, Day</i> , rear)	Hospita A hours			death occurred at	he time, date and place, and du	ue to the cause	e(s) and manner as	stated.
29b. Signature and title of certifier 29c. License number 29d. Date signed ( <i>Montin, Day</i> , rear)	Fo the   within 2 Fo the 1	complet	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.	or investigation, in	my opinion, death occurred at t	he time, date a	and place, and due t	o the cause(s)
		Ž	29b. Signature and title of certifier  Doma Wincoli, M.D.		O.C.M.E.	_		

State Registrar

5

111 Penn Street, Baltimore, MD 21201

Donna M. Vincenti, MD Assistant Medical Examiner

Date filed (Month, Pax Year) 5 2008 32. Roistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day Year) 5

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4:30 AM M Louis Howard February 24, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pineview Nursing Center Clinton Prince George's 9. Birthplace (State or Foreign Country) unk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 13, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours Min. 1 X M 2 □ F 83 220-28-6106 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Director Prince George's Suitland death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3519 Maywood Lane #1 20746 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hyglene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: <u>a</u> 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalind Alston/friend 3514 Silver Park Drive #10 Suitland, MD 20 e of Disposition (Name of Date 20c. Location - City or Town, S 20746 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of P important: if ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\\Other(\specify) in state 21. Sign yours of Europe Survey Ron 3 Le 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street S. Wade Director Baltimore, MD 21201 23a. Part Enter the disease, or complications shock, or heart failure. List only one cause is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Boy las disease or condition resulting in death) /Medical Due to (or a consequ **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to as a consequence of) P.O. Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an After this certificate has funeral director, page 2 : autopsy 1∐ Yes 2 ☑ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Man r of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Natural Injury М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Ave. Suite C-101 Clinton, MD 20735 Laxmi N. Berwa

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 5 2008

ORIGINAL

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 0443 Fletcher Hanks March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Easton 12/607 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, You Sept 23, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Year Country) Maryland 1**∑** M 2□ F 90 Director 203-09-9732 1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Talbot 0xford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 N. Morris Street 21654 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 distributor seafood 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fletcher Hanks Margaret P. Parsons ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Jane Hanks/spouse 105 N. Morris Street Oxford, MD 21654 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatury of Euneral Sorvice Lig State And tomy Board 655 W. Baltimore Street Wade, Director s 21201 <del>Bal</del>timore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A S D NOTE ON PROPERTY OF THE CONTROLL OF THE CO Approximate Interval Between Onset and Death **Physician** 0 /Medical Due t (or as a consequence of): Examiner ntra cerebral if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the bunal-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2/1 No 2.2 No 1 ☐ Yes 1∐ Yes Fo the Hospital or Attending Physiclan: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 은 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 A Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: ≠ completely filled in by the fu investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

Medical

31. Date filed (Month, Day, Year) 2008 3

Bennett

29b. Signature and title of certifier

29a. Certifier

(Check only one)

MD 219 32. Registrar's Signature

MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50

5: Washington St,

Hanks

1 🖔 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 3-16-2008

Easton,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year DAVID WEBB HERLOCKER MARCH 21, 2008 7:52 AM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CARROLL WESTMINSTER 595 SCOTT DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Months 10XM 2□ F 67 10/30/1940 TLLINOIS 358-32-6992 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2 No WESTMINSTER CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 595 SCOTT DR. 21157 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION PROFESSOR 5 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) ELIZABETH COMFORT DONALD HERLOCKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 75 LAUREL ST., BRATTLEBORO, VT 05301 DANIEL W. HERLOCKER SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ALL COUNTY CREMATION 3/22/08 SYKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Six atur of Fun ral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 te he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death mindes Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. nercholesten lem 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Triknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 TYes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner

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To the Hospital or Atter within 24 hours effer de To the Funeral Directo completely filled in by th

The law requires thet the death certificete be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

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Director

Funeral

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Physician/Medical Examiner

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permit. Pages 1 and 2 st Department of Health an important: If Item 27 is n any injury or other traur

3altimore, Maryland 21215-0020

/Medical

10a State

MD

11 Marital Status

12

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical 1 Ves 2 No

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide 29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 1005192V 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2973 Manches for RI Manches Feb. Garle 32: Registrar's Signature

State Registrar

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ For	State of Maryland	/ Depai	tment of H	ealth an	d Mental Hy	giene		
			1 - State Registrar		Cert	ificate of L	Death		Reg. No.	0000	001.15
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d	Physici /Medic		Maria G.	Irrarte				Morc		2008	14:30 M
,	Examin	er	4a. Facility Name (If not institution, give	1 100 1.11		4b. City, Town, or		eath	4c. C	ounty of Death	
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li	Funeral Director			7. Age (In yrs. las		Months Days		Min. 8. Date of B	ay, Year) 5	3 Per	place (State or Foreign Intry) U
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altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b. Plac	e of Disposi netery, crema	tion (Name of atory or other place	e)	Date	20c. Loca	ation - City or T	own, State
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בֿ	ital or irs afte ral Dir	Certification:	4   Homore	building, etc. (Specify)					own, State)		
	To the Hospital or Attending Physician; within 44 hours after death. To the Funeral Director. After this certifics completely filled in by the funeral director, to	Medical	29a. Certifier  (Check only one)  1 CertifyIng Physical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the time stigation, in my of	ne, date and p pinion, death o	place, and due to the occurred at the time	e cause(s) a e, date and p	nd manner as place, and due	stated. to the cause(s)
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ı	Physici	ian	1. Decedent's Name (First, Middle, Last)  Ac Mea Flir O heat	2. Date of Death Month	3. Time of Death
	/Medic Examir	cal	A 9 Mts tlizabeth Johns  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		C. County of Death
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	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		10d. Inside City Limits
	Ba-f sh	ctor	MD N/A Baltimore		1 ⊠Yes 2 □ No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther than "natural" for regulation at the regulation.	Completed by Funeral Director	3035 Presstman Street 21216	10g. (	Citizen of What Country?
	er deat	uner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14. Marital Status)  15. Was Decedent Ever in U.S. Armed Forces?	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	ours aft	l by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Specify: Black
21215-0036	in 72 h	oletec	15. Decedent's Education (Specify only highest grade completed)  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]	ing 16b.	Kind of Business/Industry
	filed with Hygiene. sther than	Com	Sth grade NA Clerk		Retail
Maryland	should be fill nd Mental H marked ott	To Be	William Hopkins August		ns
-	2 sho and is m		19a. Informant's Name/Relationship (Type, Print) (Paughter) 19b. Mailing Address (Street and Number or Rur Margo Z. Guy-Burris 3406 Mamon AV		or Town, State, Zip Code) 21207 117More MD
Baltimore	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1 Description 3 Removal from State  20b. Place of Disposition (Name of cemetary, crematory or other place)  Carrison Forest  03	6	Location - City or Town, State
Balti	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Licensee  22. Name and Address of Facility \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	John C. Gre	town NO 2133
			23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or bean adjure. List only one cause on each line.	101.	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a		Onset and Death
	Examiner				
Ţ	outed Id ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
8760,	sician and burial-transit		resulting in death) Last  Due to (or as a consequence of):		
9	rtificate Ing physical as the t	Medic	IF FEMALE:		
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2		23d. Date of delivery Month Day Year
	res that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ord	w require been si should I	eted	MYPERTENSIVE CARDIUVASCULAR DISEASE		2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	The lay ate has page 2:	Completed	TYPE IL DIABETES MELLITUS	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 20000
Vita	Physician: Th this certificate ral director, pag	Be	examiner:	h (Check anly one)	
n of	<u>a</u> = <u>a</u>	on: To	1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Ho	me 5 Residence 28d. Describe how inj	
isio	or Attending P after death. I Director: After t d in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be	20f Lanting (Street)	and Number or Rural Route Number,
Ö	Ital or / irs after ral Dire led in b	Certi	4 Homicide determined building, etc. (Specify)	City or Town, Sta	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause( red at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To ti withi To ti	M	29b. Signature and title of certifier  29c. License number		Pate signed (Month, Day, Year)
7	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		3-19-2008
	U			STERSTOWN	MD 21136
	Sta Registr		KALU UMA ZIV BUSNESS CENTER DRIVE, REI  31. Date filed (Moder DJP, Year 2008)  32. Registrar's Signature		

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 23 2008 Year **Physician** Miriam L. Jones 4:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Riverview Nursing Home Baltimore Essex If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) January 13, 1921

9. Birthplace (State or For Country)
Pennsylvania Birthplace (State or Foreign Country) Funeral 1□ M 2ĂF Months Days 216-12-0073 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo **Funeral Director** Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 3834 Annadale Road USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 12 years Housewife Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked any injury or control. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Clark Fred Herman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3834 Annadale Road, Dundalk, Maryland 21222 Wayne W. Jones son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20a. Method of Disposition 20c. Location - City or Town, State Marchi 24, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Demonter. duance d un- Known Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Author, within 24 hours after death.

To the Funeral Director: After this certificate I 210 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manger of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 03-23-2008. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21221. 709. MALIKA WASBEM. 31. Date filed (Month, Day, Year) MAR 2 5 2008 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		_ State	State of M	aryland /		rtment of H		Mental Hy	/	108	09418
h 3		Registrar  1. Decedent's Name (First, Middle, Last)				incate of L	Jean	2. Date of De	Reg. No		3. Time of Death
Physicia		Craig Knoferle						3-22-	Day 2	2008ar	5:00P.M. <sup>M</sup>
/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)			4b. City, Town, or	Location of Dea	th	4c. Cour	ity of Death	75.001.111
		12658 Wilson Av				Fork ,					
Funeral		5. Social Security Number 6. Sex	7. Ag 1 2□ F   6	je (In yrs. last b $1$	oirthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Year)	Coui	
Director		217-48-8353 Usual Residence of Decedent						1-2-194	+ /	Mc	1.
how at	. [	10a. State 10b. County		10c. City, To	wn or Loc	ation					10d, Inside City Limits
e Ma Ba-f s	cto	Md. Fork		F	ork,						1 ☐ Yes 2 🙀 No
with the	Funeral Director	10e. Street and Number 12658 Wilson Aven	ue			10f. Zip Code 210	)51		10g. Citizen o	f What Cou	ntry?
ms 23	eral	11. Marital Status 12.	Was Decedent	Ever in U.S.	13. V	/as Decedent of Hi	spanic Origin? (	Specify Yes or No		ace - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:			Yes, specify Cuba  ☐ Yes 2☐ No	n, Mexican, Pue Specify:	rto Hican, etc.)	Spec	lack, White, cify:	White
2 hour		15. Decedent's Educat	ion	16		ent's Usual Occupa		- defe	16b. Kind of	Business/In	ndustry
thin 7. ie. Medi	Completed	(Specify only highest grade c	College (1-4or	5+)	(Give I life. E	kind of work done of O NOT use retired,	furing most of we )	orking			
led wi lygien ner th		12			Pres	sman	40 14-45-3-15	/Einst ##/###	Publis		Co.
d be fil	Be c	17. Father's Name (First, Middle, Last)  Herbert Anton Kno	forlo					me (First, Middle ret Mary		•	
should nd Me mark matic	၉	19a. Informant's Name/Relationship (Type		19	b. Mailin	g Address (Street a					p Code)
alth ar 27 is 27 is er trau		Carolyn Knoferle	Wife		1	2658 Wils	son Aven	ue Fork,	Md. 21	051	•
es 1 a of Her fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	oval from State	cemei	of Dispos tery, crem	sition (Name of natory or other place	e) :	Date	20c. Location	n - City or To	own, State
Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		Bayv				-2008		Balto.	. City
permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	a Qo			. Name and Addres himunek I	•	Home 970	)5 Bela	ir RD.	
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that cause cause on each l	d the death. Do	not ente	er the mode of dying	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Chro	a consequence	3/1	active	Pulm	snarry 8	) seas	4	Sychast and Death
Examiner		Segrentially list conditions b.	Due to (or as	a consequence	e orj:						
ag A g	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e ot):						
physician and the burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as	a consequence	e of):						
tte be nysicia ne bur	dical	d.									
ertifica ing ph e as tl	Φ	IF FEMALE:			-						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)				Date of deliv Month	very Day Year
w requires that the d been signed by the should be detached		Part II. Other significant conditions contri	outing to death t	out not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
quires en sigr uld be	ed by	Diabetes	Well.	The				)×	Yes 2□ No	3 □ Pro	bably 4 □Unknown
law re	Completed	Drafy/	proti	1 He	W	10126	MSP	24a. Was		b. Were auto	opsy findings available ompletion of cause of
rsiclan: The law s certificate has b lirector, page 2 s	E O	Tobreco.	Abusp	)		-			ormed? 2KINo	death?	2□ No
clan: ertific ector,	Be (	25. Was case referred to medical examiner?	nital:			1011		eath (Check only	one)		
Physic this cral dire	٦.	1 ☐ Yes PANo Pios 27. Manner of Death	pital: 1 ☐ Inpati 28a. Date of Inj		Outpatient . Time of		4 LI Nursing	Home 5 Res	idence 6 🗆 C		ify)
ding h. : After	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da		Injury	28c. Injury Work M 1 □	(? Yes 2 □ No	200. Describe	now injury occ	unea	
Atter er deal ector by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in	jury - At home, tc. (Specify)	farm, stre	et, factory, office			(Street and Number, State)	mber or Rur	ral Route Number,
ital or irs afte ral Dli lled in	Cert						W	1			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  Certifying Physic 2 Medical Examine	ian: To the best r: On the basis of and manner si	or examination a	ge, death and/or inv	occurred at the time estigation, in my of	ne, date and place pinion, death oc	ce, and due to the curred at the time	e cause(s) and , date and plac	manner as se, and due	stated. to the cause(s)
To th Withir Comp	Me	29b. Signature and title of certifier	(I-a	7		29c. License	number	//	29d. Date sig	ned (Month,	, Day, Year)
		30. Name and address of person who com	oleted cause of	Death_(Item 23a	) (Type. F	Print)	00455	>4	17/a7	h Z	7,2000
6		Millary K. Humo	22 1	ND.	2.3		ut Rd.	Fulls	ton, N	W. 2	104+
Sta Registra		31. Date filed (Month, Day, Year)  MAR 2 5 2008	32. Hegist	rar'i Signatu	BILL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore mane lale ose If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, O2 | OL Social Security Number 6. Sex (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🗹 F 215-40-8229 Pennsylvania Director Ole Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 NO Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 280 212 34 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ome maker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Kovacs 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 is
any Injury or other trau Baltimore, MD. taloni/Daughter 2802 Chenoak 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 Removal from State 03/ 08 Stanislaus Cemeter 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Pacifity Everns Funeral Chapet + Cremation, Services 18800 Harford Rd. Parkville, MD. 21234 21. Signalure of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heaf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immy diate Cause Final Due o (or as a consequence of): **Physician** is ase or condition resulting in death) /Medical Examiner ensis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Post Exploratory Laprotomy Small Bowel resection burial-transit or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical as the l IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy detached for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the a□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2

No 3 Probably 4 Unknown 1 🗌 Yes eblacemen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed Atmial FIBN 25. W s case referred to medical examiner? certificate 1□ Yes Physician: completely filled in by the fureral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? within 24 hours after death. To the Funeral virector: After 1 Natural
2 Accident To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 19/2000 0000

DHMH 17 Rev 1/2001

State Registrar JAFAL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Fran Klin Square
32 Registrar's Signature

SHETTY

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show important: If term 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 than the M

> **Physician** /Medical Examiner

The law requires that the death certificate be executed the attending physician hed for use as the burial signed by to After this certificate To the Hospital or Attending Physician; within 24 hours area ....

To the Funeral Director: Aftreated filled in by the fur

Division or Vital Records, P.O. Box 68760

Month **Physician**  $2^{Day}$ John Ε. Kahler March 2008 4:15 a <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6904 Columbia Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 212-34-7049 71 **Director** JUL 16 1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2N No Director MDBaltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6904 Columbia Road 21220 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Kahler Gladys Coss 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. Kahler - Wife 6904 Columbia Road, Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory, Inc. 3/24/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Williams <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIL disease or condition resulting in death) Due to (or as a consequence of): schenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform ocriphera 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one Hospital: Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hos 183 DRIVE 0 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 25 2008 Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene											
			1 - For State Registrar	State of M	larylan		artment of <b>F</b> <i>rtificate of</i>		lental Hy		0000	00101
-th-		-	Registrar  1. Decedent's Name (First, Midd	dle, Last)		00	i lilicale oi	Dealli	2. Date of D	Reg. No.	2110	3. Time of Death
	Physicia /Medic		YongBok Kar	ıg					March	22 22	2 2008	9:00 a <sup>M</sup>
	Examin		4a. Facility Name (If not instituti		-)			r Location of Death		4c.	County of Deat	_
			3701 Takoya Dr  5. Social Security Number		ne (In vre	last birthday)	Ellico	tt City If Under 24 Hrs.	8. Date of Bi	rth	Howard	hplace (State or Foreign
	Funeral Director		213-08-0678	1 <b>⊠</b> M 2□F	83	Yrs.	Months Days	Hours Min.	AUG 2:	ay, Year)	l Co	untry)
7	pu ,		Usual Residence of Decedent  10a. State 10b. Count			y, Town or Lo	neation		1			10d. Inside City Limits
	Aaryla f shov ed at	or										1 Tyes 2 No
	r 28a-	irect	MD How 10e. Street and Number	mard		TICOL	t City 10f. Zip Code			10g. Cit	izen of What Co	ountry?
	th with	Funeral Director	3701 Takoya Dr	ive			2104	2			Korea	
	er dea	nuel	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecity Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit	
35	urs aft	by F	1 □ Never Married 2 Ma 3 □ Widowed 4 □ Divorce	If Yes Give	-		1 ☐ Yes 2 No	Specify:			Specify: As	sian
215-0036	72 hou natura ilical E	eted	15. Decede	ent's Education lest grade completed)		16a. Dece	edent's Usual Occup	pation during most of work	kina	16b. K	ind of Business	Industry
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or thems 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)		5+)		DO NOT use retire todian	during most of world)	5	Hic	gher Edu	action
12 D	al Hygie other	Be Co	17. Father's Name (First, Middle	 9, Last)		Qus	COGIAN	18. Mother's Nam	e (First, Middle			icación
Maryland	O 10 TT 41	To B	Jaesoo Kang	; >				CiCi	Kim			
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	es 1 and 2 of Health a item 27 is other trau		Sue Yim - Daug 20a. Method of Disposition	nter	20b. F		Hermitagosition (Name of ematory or other pla	ge Drive,	ELL1CO Date		cation - City or	21042 Town, State
Baitimore,	Pages nent of int: If its iry or o		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other					Inc. 3/24	1/2008		ltimore,	
alt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service					ess of Facility n Society erick Roa				
10	9 2 E 9		- All								re, MD	
			23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	or complications that cause st only one cause on each	line.	n. Do not en	iter the mode of dyl	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Hypel Due to (or a	S a conseq	uence of):						Unk
	Examiner		Sequentially list conditions.	b. Dysl	ip ide	emia						unk
/	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d Due to (or a Rena	is a conseq	uence of):	Ficiency					unk ~ 4 mones
), ),	be executed cian and ourial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or a			7					7 2200100
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9 ×	leath certificate be attending physici I for use as the bu	Physician/Medica	IF FEMALE:	23c. If yes, outcom	e of predna	ancv					00d Date of de	U
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ďs,	w requires that been signed to should be deta	þ	Part II. Other significant condi	tions contributing to death	but not res	uiting in the i	underlying cause gr	ven in Part I.				o the cause of death?
Vital Records,	w requ	Completed							24a. Wa	s an	24b. Were a	utopsy findings available
¥ Y	The law cate has page 2.	ошо								opsy formed? 2 No	prior to	completion of cause of
/ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medic examiner?					26. Place of Dea				
0	Physi r this o ral dire	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpa		ER/Outpatie	III 3 DOA	her: 4 Nursing H	ome 5 Res		6 □Other (Spe	ecify)
<u>o</u>	nding Ph ith. r: After th e funeral	ation	1 Natural 5 ☐ Pend	/Adomatic E		Injury	Wo	rk? ]Yes 2∐No	Zou. Describe	o now mja	ny occurred	
Division	r Attend ter death. irector: /	Certification:	3 Suicide 6 Coul 4 Homicide dete	rmined   28e. Place of II	njury - At h	ome, farm, si fy)	treet, factory, office			(Street a		ural Route Number,
	pital c		29a. Certifier 1 Certify	ring Physician: To the bes	et of my kno	wledge dea	th occurred at the t	ime date and place	and due to th	0.00100/0	and manner o	a atata d
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medic	al Examiner: On the basis and manner:	of examina	ation and/or i	nvestigation, in my	opinion, death occu	rred at the time	e, date an	nd place, and du	e to the cause(s)
	To the comp	M	29b. Signature and title of certi	ier				se number			ate signed (Mon	32 -
)	10		my	kr.	mo		<i>D</i> S	\$978		03	, 24, 2	.008
	10		30. Name and address of person	on who completed cause of	death (Iter	n 23a) (Type 1 <b>o r.e</b>	Nations	1 Fike,	Ellicot	t ci-	ty mo :	21043
	Sta		31. Date filed (Month, Day, Yea	(r) 32. Regis	strar's Signa	ature	Scarte	-,			1	d+
	Regist	rar	mar a	o root	A fair least	20 1	April 10 min					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 22, 2008 1:05 P M Theresa Kaludis March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death William Hill Gardens Assisted Living Easton Talbot 8. Date of Birth (Month, Day, Year) Dec. 15, 1915 Greece If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 257 F 216-28-2561 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Talbot Easton 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 7667 Tred Avon Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 S Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Owner** Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kyriakos Topal Irene Tsakiris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7667 Tred Avon Circle; Easton, Maryland 21601 Karen Kaludis Filbert Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/25/2008 Greek Orthodox Cem. Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signal e of Juneral Service Lio-1039 MD 21228 1630 Edmondson Avenue; Catonsville, Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acom Due to (or as a cont if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence.of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent prognant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an was an autopsy performed? 1∐ Yes

Physician /Medical **Examiner** 

be executed

P.O. Box 68760,

Division or Vital Records,

Attending

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

r 28a-f show notified at

ms 23a or 7

7 is marked other than "natural", or items traumatic event, the Medical Examiner m

al Hygiene.

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Department of Health ar Important: If item 27 is any injury or other traugonce.

Director

Funeral

Completed by

Be

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with the Maryland

death

filed within 72 hours after

Pages 1 and 2 should be

Maryland 21215-0036

Saltimore,

attending physician for use as the buria ed by the a signed by t certificate has director, After 1 death.

Examiner Physician/Medical <u>Ş</u> Completed Be ٥ Certification: Medical

25. Was case examiner? 27. Manner of Death

in by the funeral or Attendate death To the Hospital of within 24 hours of To the Funeral D completely filled

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

28c. Injury at Work?

1 🗌 Yes

2 □ No

29d. Date signed (Month, Day, Year)

6 Dother Specify

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Name and address of person ath (Item 23a) (Type, Print)

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

2 No

5 Pending investigation

6 ☐ Could not be

determined

1 ☐ Yes

1 atural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan						ental Hy	giene		00100
			Registrar	14)		Ce	rtificate	e of L	Jeath	)		Reg. No.	2008	09423
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	/Medi		4a. Facility Name (If not institution,			Kallsii	4b. City,	Town, or	Location		Haren	<del></del>	County of Death	
	Exami	ner	Suburban Hospi		,0.7			thes		0, 20011			ontgomer	
Ī	Funeral Director	7			. Age (In yrs.	la <i>st birthd</i> ay) Yrs.	If Under Months			Min.	8. Date of Bir (Month, Da May 22	th	9. Birth	place (State or Foreign ntry) York
	pu ,		Usual Residence of Decedent		100 0	. Town as l	antian .							
	laryla shov	5	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
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	ms 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13.			spanic O	rigin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ameri	
Maryland 21215-0036	- <b>29</b> - 20	by	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Force d 1 □ Yes 2 If Yes, Give Year or Date	. No		1 ☐ Yes 2		n, mexica Specify		Rican, etc.)		Black, White, Specify: Wh	etc. iite
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Z	shou and M mar umat		19a. Informant's Name/Relationshi	(Type. Print)		19b. Mailii	ng Address	(Street a	and Numb	er or Rura	I Route Numb	er, City o	r Town, State, Zi	p Code)
	and 2 salth s		Leslie Kalish (	Son)		386 C	entra	1 Av	e.,	Needh	am, MA	0249	94	
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	B □ Removal from St		lace of Dispo emetery, cre	osition (Nam matory or o	ne of ther place			ate	20c. Lo	cation - City or T	own, State
Ë.	Pag tment tant: jury o		4 □ Donation 5 □ Other (Spe	ecify)		trepos			· :	3/21/		King	gston, N	Y
Baltimore.	permit Depar Impor any in		21. Signature o Funeral Service L	pensee Hends	20	S 4	2 Name and impsoi 11 All	d Addres n-Ga bany	s of Facil us F Ave	<sup>lity</sup> unera ., Ki	1 Home	, NY	12401	
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7	/Medical Examiner		resulting in death)		nary A		01000	o i o						
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Sã	s after s after al Dir	Certification:	4 ☐ Homicide determin	building	, etc. (Specify	V)					City or To	wп, State,	)	
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			ma	ue &	Le	2	4	2181				Marc	h 20, 20	008
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Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

funeral To the Hospira... within 24 hours after death.

To the Funeral Director: Aft

by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as a consequence of):  C										
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopic			23d. Date of de Month	elivery Day Year						
	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.		use contribute t	to the cause of death? Probably 4 (Unknown						
Completed					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of						
Be (	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)								
10 E	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	ER/Outpatient 3⊓ I	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)						
	27. Manner of Death 11 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred							
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dical		hysician: To the best of my kn miner: On the basis of examin and manner stated.											

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of

30 Name and address-or

31. Date filed (Month, Day,

2008

(Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Robert 6:38 pM Irwin March 2008 /Medical 4a. Facility Name (If not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex Baltimore 9. Birthplace (State or Foreign Country) Brooklyn, N. Y. anter 7. Age (In yrs. last birthday) 80 vrs 8. Date of Birth (Month, Day, Year) NOV • 29 , 1927 **Funeral** Months Days DOM 2□F Hours Min 113-20-0713 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore County Pikesville Director Maryland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1415 Bedford Ave. 21208 Apt. 414 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 12 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ş W.W.II 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Levy Marion Shipman ို 19a. Informant's Name/Relationship (Type. Print) Wlfe) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Sandra Jean(nee Pressley)Levy 1415 Bedford Ave. Apt.414 Pikesville,MD.21208 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel Date 20c. Location - City or Town, State March 22, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A
2325 York Road Timonium, Maryland 21093 aur 23a. Part I that the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myscerdia W. Jaketon 4 Duns /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig , page 2 should b Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | performed 1 ☐ Yes 21110 1 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ **(**10 Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1. Natural Injury death. after death. 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) March 20th. mp 054632 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Randa ISTOWN

32. Registrar's Signature

Registrar

State

Day, Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mobled Month 20 200 S Donald march /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard County General Hospital Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 212-62-2570 68 Director Apr. 19, 1939 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Woodstock 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1709 New Hampton Lane 21163 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1X Never Married 2 - Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Edward Mobley, Sr. Catherine D. Wrightson 19a. Informant's Name/Relationship (Type. Print)

Joan Harkum - Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 New Hampton Lane, Woodstock, MD 21163 Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Parkwood Cemetery 3-22-2008 Baltimore, MD 4 Donation 5 Dotner (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. abyro o Runeral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sacteri /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit a g Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1∏Yes 2∏No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salsanetts 32 Registrar's Signature PERSON

Back Riva Neck Road Ballims nayling 201-109

30641

# Baltimore, Maryland 21215-0036

			State of Maryland				-	-	e.	
	State of Maryland / Department of Health and Mental Hygiene  1 - State of Maryland / Department of Health and Mental Hygiene  Certificate of Death									
11		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	eath 4	3. Time of beath	
Physicia /Medic	_	Marjorie	A. Mac	dile			March	Day Y	6:30 A M	
Examin		4a. Facility Name (If not institution, give	street and number)	)	4b. City, Town, o	r Location of Deat		4c. County of		
2.		Good Samaritan Nur 5. Social Security Number 6. S	sing + Kehab Co	enter	If Under 1 Year	Itimor		41.	D. H. J. (2)	
Funeral Director			7. Age (In yrs. I	<i>iast birthday)</i> Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country)	
		Usual Residence of Decedent	, 00				Nan 19	,1928 15	cranton, PA.	
ihow tat		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
8a-fs	Director	MD (Dalt	rimore	1	arko	ille			1 □ Yes 2 No	
a or 2	Dir	10e. Street and Number	<b>^</b> .		10f. Zip Code	001		10g. Citizen of Wh	at Country?	
death with the Maryland ms 23a or 28a-f show r must be notified at	eral	8604 Midi	12. Was Decedent Ever in U.	S 12	Was Decedent of H	d 34	nacify Vac or No	U S 1-	American Indian,	
riten riten iner	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼ No		If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		White, etc.	
ral", o Exam	þ	3 N Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No	Specify:		Specify:	white	
illed within 72 hours after Hygiehe. other than "natural", or ite ent, the Medical Examine	Completed	15. Decedent's Ec (Specify only highest gra	lucation ade completed)	(Give	dent's Usual Occup kind of work done	during most of wo.	rkina	16b. Kind of Busin	ness/Industry	
within the	Id I	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d) -		., ,		
Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		1715	iting	18 Mother's Nar		Home F , Maiden Surname)	lealth Care	
o be ked o c eve	To Be	Vita ma	2012		_	$\sim$	Idrec	Gat	^	
snould be ind Mental marked c	F	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailii	ng Address (Street	and Number or Ri		er, City or Town, St		
and 2 ealth a n 27 Is er trau		Anthony Pagnott	ri-nephew	14107	Wooden	slane	Reisters	stown m	D 211310	
of He		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. P	lace of Dispo	sition (Name of matory or other pla	T T	Date	20c. Location - Ci		
rages ment of ant: If It ury or o		4 Donation 5 Other (Specific		moria	valley 1 Garde	ns 3/21	0/2008	Timoni	um, MD.	
permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	isee	E.	2. Name and Addres	ess of Facility	apel + Cr	emations	Services Parkuille	
20 2 8 O		Stace of	martin	18	800 Har	ford Roc	ad Parl	wille m	1D 21234	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line		er the mode of dyl	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death	
hysician /Medical		disease or condition resulting in death)	a. ASU							
Examiner			Due to (or as a consequ	1 + N	TIA					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):							
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certii nding Ise as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	псу				23d Date	of delivery	
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been signed by the should be detached	by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?	
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has bi ge 2 sh	Completed						24a. Was	psv pri	ere autopsy findings available or to completion of cause of	
icate r, pag							1□ Yes		ath? Yes 2 No	
sician: certific irector,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ED/O	oth	ner:	ath (Check only			
arthis eral d	<b>⊢</b> ⊦	27. Manner of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury	28b. Time o	IL 3 DOA	4 Nursing I	T	dence 6 Other	(Specify)	
r death. ector: After toy the funers	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No				
irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office	1	28f. Location (	Street and Number wn, State)	or Rural Route Number,	
urs aff						<u> </u>				
To the rospital or Attending Priystolar: The law required within 24 hours after death.  To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should be a completely filled in by the funeral director, page 2 should be a completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	uysician: To the best of my kno- niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date and plac- opinion, death occ	e, and due to the urred at the time	cause(s) and manr , date and place, an	ner as stated. d due to the cause(s)	
within 2 or the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (	Month, Day, Year)	
- > - 0		Mar MD			05	7727		3/25	108	
,0		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)		1	3/25 R. MD	21234	
1		Naundel Bho	man 8813	War	Whem	woods	Mone	K.WD	21234	
Sta		31. Date filed (Month, Day, Year)	32. Poistrar's Signa	ture	0					
Registr	ar	MAR 2 5 2	2008 Geene	K A	ocal o					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / De	partment of F ertificate of	Health a	and Me		giene Reg. No. 2008	09428		
21	D.C.		Decedent's Name (First, Middle, Last)					ath	3. Time of Death		
s-	Physici Medic		Audrey Laverne McIntyre				Month	Day Year	1:04AM		
7	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location	of Death		4c. County of Dea	ih		
22			Union Memorial Hospital		imore						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under Hours	Min.	<ol> <li>Date of Birtl (Month, Day</li> </ol>	v, Year) Co	hplace (State or Foreign buntry)		
	Director		214-14-3322   TIM ZIAF   88 Yrs. Usual Residence of Decedent			,	June 2	5,1919 Mary	land		
	and w		10a. State 10b. County 10c. City, Town or	Location					10d. Inside City Limits		
	Mary f sho	jo	Maryland Baltimore Catonsvi	1110					1 ☐ Yes 2 K No		
	r 28a	Director	10e. Street and Number	10f. Zip Code				10g. Citizen of What Co	untry?		
9	h with		719 Maiden Choice Lane BR238	.228			USA				
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was Decedent of I If Yes, specify Cub		igin? (Spec	ify Yes or No-	14. Race - Ame			
	after or ite mine		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☑ No			ican, etc.)	Black, Whit	•		
215-0036	ours ral",	d by	3 Midowed 4 Divorced Year or Dates:	TEL TOO ELEMINO	орсспу.			Specify: 1122			
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	within	du	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retire Homemak	•			Own Home			
2	Hygie Hygie Theri		17. Father's Name (First, Middle, Last)	Homemak		er's Name	(First Middle	Maiden Surname)			
au	d be	) Be	Harry M. Cummins		1			ntgomery			
$\mathbf{z}$	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	은		iling Address (Street	t and Numbe	er or Rural	Route Numbe	er, City or Town, State, 2	Zip Code)		
Baltimore, Maryland 21	nd 2 alth a 27 is r trau							g, Pennsylv			
ē,	is 1 a		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other pla	1	Da		20c. Location - City or			
Ë	Pages nent of I ant; If Its ury or o		A Bunal 2 Cremation 3 Removal from State	e Park Cen	· · · · · ·	3/26/2	2008 W	oodlawn, Ma	arvland		
<u>a</u>	permit. Page Department of Important: If any Injury or once,							shton Schwa			
n	o a E e	U 10	Me Sell Menon	uneral Ho 1630 Edmon	ome or adson	Avenu	nsvill e: Cat	e,inc. onsville, N	D 21228		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.						Approximate Interval Between		
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	/Medical		resulting in death)  Due to (or as a consequence of):								
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280	ficate physis the	edic	d								
XOR	the death certifics y the attending ph tched for use as th	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	_				23d. Date of delivery Month Day Year			
ň	death e atte d for	icia	in the past 12 months?  1 Yes 2 Mo  4 Pregnant at time of death	B□Ectopic pregnanc B□ Other (s <i>pecify</i> ) _							
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ပ္ပ	law re as be 2 sho	Completed					24a. Was a		itopsy findings available completion of cause of		
r	rsician: The law s certificate has t lirector, page 2 s	ĕ					perfor	med? death? 2 ☑ No 1 ☐ Yes			
<u> </u>	is certific director,	Be (	25. Was case referred to medical examiner?		26. Place	of Death	Check onl or				
0	Physician: r this certific ral director,	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpati	CIR DON		ursing Hom	e 5 🗆 Resid	ence 6 □Other (Spe	cify)		
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SION	teath leath tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of injury. At home form		Yes 2						
$\leq$	al or Attending F s after death. Il Director: After d in by the funera	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, shuilding, etc. (Specify)	street, ractory, office		28	If. Location (S City or Tow	treet and Number or Run, State)	ıral Route Number,		
_	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the ti	me date ar	nd place, as	ad due to the	cauco(c) and manner as	stated		
	24 hos 24 hos Fun etely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my	opinion, dea	ath occurre	d at the time,	date and place, and due	to the cause(s)		
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Me	29b. Signature and title of certifier	29c. Licens	se number		2	29d. Date signed (Mont	h, Day, Year)		
)	/		Ros O. Tomir	AT2	4330	146		March 2:	2,2008		
	15	+	30. Name and address of person who completed cause of death (Item 23a) (Typi	1 1 2		-					
	17		Belinda Escanio, M.D. Unic	on Memoria	al H	oupit.	1				
j	Sta	_	30. Name and address of person who completed cause of death (Item 23a) (Type Belinda Escanio, M.D. Unic 31. Date filed (Month, Day, Year)  MAR 2.5 2008  32. Ingistrar's Signature	hastes							
	Registr	ar	MAK & D COOO LAND	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mitchell 3:00A M 2008 HONE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Hospice 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 □ F 214-38-8822 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore be notified 1/□Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Nauth 19, 2008 ŏ Ave Apt 312 owanda Ave Apt

12. Was Decedent Ever in U.S.

Armed Forces? 21215 Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ₩0
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 215-0036 'naturai", or 1 ☐ Yes 2 ☐ No δ 3 ☐ Widowed 4 ☐ Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant 2 Assisted ( 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Singleton Marie ones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. Walter D. Mitchell Avenue Baltimore MD 21215

Date 20c. Location - City or Town, State 3000 lowarda boune 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation Garnson Forest 3/as/aco8 Baltimore, MI) 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugnon C. Oreene Fureral Services 21. Signature of Funeral Service Licensee Vaughn C. Hreene 4905 York and Baltimore N

23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed physician and is the burial-tran Due to (or as a consequence of): Physician/Medical as attending plant of the season IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed?

1 Yes 2 No certificate or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation within 24 hours are to to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of ortifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Colto Md 120 01 K. 31. Date filed (Month, Day, Year) MAR 2 5 32. Registrar's Signature State 2008 Darke Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 🏻 🗎 🥈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4.45 AM eresa 2008 MARCH 18 /Medical 4c. County of Death 4a. Facility Name (If,not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bal Baln Mare
If Under 1 Year | If Under 24 Hrs. Date of Birth Social Security Number yrs. last birthday) 8. 9. Birthplace (State or Foreign **Funeral** Months . Days Min. Cour Hours 1 M 2 C Director Yrs Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Madical Exeminar must be notified at 1 Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21313 . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Meceptionist year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itam 27 is marked o verna ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pote 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Greenmant Crematory 3 ount Genetary 3/20/2008 Baltimore, MI)
22. Name and Address of Pacility Cremation Services Injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee any le 5151 Galtimore National Pike Baltimore MD21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner this certificate hes been signed by the ettending physicien and al director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed 1 Yes 25 No After this certifical funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 SInpatient 1 Tes 32 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the Diractor: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a To the Funeral C 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Keith 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS Hopkins Hosp 32. Registrar's Signature 600 North Wolfe STREET, BAH, MORE NO 21287 State A SECOND Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Vear 5,459M Sylvester Frank Mattheu 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Himore Franklin 394are
5. Social Security Number Hospital KO 15 Under 1 Year | If Under Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 02/09/1920 9. Birthplace (State or Foreign **Funeral** Hours Days Min. **X** M 2 □ F 218-01-6807 Maryland 88 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ortant; if Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, <u>the Medical Examiner must be notified</u> at Maryland Baltimore Essex 1 TYes 20XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 1041 Foxwood Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examines once. 1944-Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2□ No 21215-0036 1 ☐ Yes XX No Specify: White þ 1946 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Barbara M. Goepfert Frank J. Mattheu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LeRoy Mattheu (Son) 543 Grovethorn Road, Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/27/2008 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Parvice 116 Insec 1407 Old Eastern Avenue, Essex, Maryland 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate ause (Final disease of condition resulting in death) **Physician** Intracrania Week /Medical Due to (or as a consequence of) Examiner birucle accid uma to hear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (up s a consequence of) Examiner The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes 20 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 1□ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Nanatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: : After 5 Pending investigation 1 Natural Bicycle-caracciden March 17,2008 1830 P M 12 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 Accident Director 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Mulagueand Lutz Acc 4 Homicide Public ESSOX Maryland 21221 24 hours e e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 1006315 ted cause of death (Item 23a) (Type, Print) O Franklin Square Drive Baltimore, Maryland 32. Registrar's Signature State Registrar 2342

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl		artment of F rtificate of			and the	080	9432	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Loretta					2. Date of Demonstrated March	Day	Day Year		
	Examir		4a. Facility Name (If not institution, give s 65 Cool Breeze				r Location of Death		4c. County Balt:	of Death		
	Funeral Director		213 20 0375	7. Age (In	yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day February	18,1930	9. Birthplace (S Country) Marylar	tate or Foreign	
perinitione, Mar yiallo 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	ne Maryland 8a-f show ptified at	ctor	Usual Residence of Decedent  10a. State  Maryland  Baltimor		: City, Town or Lo						de City Limits	
	h with the	al Dire	10e. Street and Number 65 Cool Breeze Dri	.ve		10f. Zip Code 21		10g. Citizen of W USA	/hat Country?			
	ours after deat ral", or items 2 Examiner mu	by Funeral Director	11. Marital Status 1 1 □ Never Married 2 □ Married  ③ □ Widowed 4 □ Divorced	2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify	e - American India k, White, etc. White	iπ,	
	within 72 ho ene. Ihan "natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give	Give kind of work done during most of working life. DO NOT use retired)				6b. Kind of Business/Industry		
	uld be filed a Mental Hygid arked other attic event, the	To Be Co	8 years  17. Father's Name (First, Middle, Last)  Joseph Bunk		Se	18. Mother's Name (First, Middle, Maide) Julia Fox				el Company en Surname)		
	1 and 2 sho Health and I em 27 is me ther traume			Daughter	2311	ng Address (Street Searles	Road, Du	ndalk,MA	ryland	21222		
	nit. Pages artment of I ortant: If ite Injury or of		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)  21. Signature of Funesal Service License	F Community of the comm	OTTA HI	osition (Name of matory or other place 11 Memori	al large	008	Middle H			
	Physician /Medical		23a. Part1. Enter the disease of complic shock, or heart failure. Lie only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the decause on each line.	death. Do not en	1.1	rs Point	Road, D	rest,	MD. 212 Appro	ximate all Between and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed	tificate be executed g physician and x as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C									
	attendin for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	sc. If yes, outcome pf pro 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetal death 3[	Ectopic pregnanc	у		23d. Date Mor	e of delivery nth Day	Year	
	equires that en signed by ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown								e of death?	
	To the Hospital or Attending Physician: The law requires that the dividing 42 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	e Completed	25. Was case referred to medical				Of Plans of Das	1□ Yes -	rmed? d	Vere autopsy find rior to completion leath? ☐Yes 2☐ No	n of cause of	
	hysicia this cert	To Be	examiner?  1   Yes   2   No									
	Attending F or death. ector: After by the funer	Certification:	27. Manner of Death    Natural   5   Pending   investigation   3   Suicide   6   Could not be   determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - A building, etc. (Sp		M 1□	yat k? Yes 2∐No	28f. Location (S	now injury occurre		Number,	
2	spital or ours afte neral DIr / filled in		29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated									
	the Ho thin 24 I the Fu mpletely	Medical	one) 2 Medical Examin	er: On the basis of exar and manner stated.	mination and/or in	vestigation, in my	opinion, death occu	irred at the time,	date and place, a	and due to the ca		
	N Wil		29b. Signature and title of certifier	DHUCT	LA	29c. Licens			29d. Date signed		2.4	
	12		30. Name and address of person who cor	npleted cause of death	(item 23a) (Type,		2284-	13 1	NARCH	24,2	200	

Registrar

31. Date filed (Month, Day, Year)
MAR 2 5 2008

DHMH 17 Rev 1/2001

PITUIP NIVATPUNIU 9114 PHILADRLPHIA ROAD BACTINCRE NO 2(23)
31. Date filed (Month, Day, Year)
32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of H		d Mental H	ygiene	008	094	33	
B	Physici		1. Decedent's Name (First, Middle, La. Bessie	Moo he				2. Date of D Month	Day	Year 2.008	3. Time of	Death A M	
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of D		4c. Co	unty of Death			
			Liberty Heights			Baltim							
	Funeral Director		5. Social Security Number 6. S 217–20–3312	□M 2MF	Vre	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, L	Day, Year)	Coun	ace <i>(State</i> o try) Carol		
	D		Usual Residence of Decedent		32			Nov 1,	1925	NOTCH	Calu	LIIIa	
	larylar show	ř	10a. State 10b. County		, Town or Lo					10	0d. Inside Cit 1√2 Yes		
	the N	rect	MD  10e. Street and Number		altimo	10f. Zip Code			10a, Citizer	of What Coun			
	th with	al Dì	1701 Eutaw Place	#610			217			USA	-,		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 □ Yes 2 <b>X</b> No	spanic Origin n, Mexican, F Specify:	? (Specify Yes or Nouerto Rican, etc.)		Race - America Black, White, onecify: bla	etc.		
21215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Deced (Give life. I	dent's Usual Occupa kind of work done d OO NOT use retired)	ation Juring most of	f working	16b. Kind	of Business/Ind	lustry		
7	lled wi fygien her th nt, the	S	10 17. Father's Name (First, Middle, Last)	0	<u>b</u>	armaid	10 Mathada	Name (First, Middl	  - Maid== 0	bevera	ge		
and	ld be fi ental H ked ot ic evel	To Be	Floyd Moore					arta Broo	,	rname)			
ary	shoul and M s mar	۲	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	g Address (Street a	nd Number o	or Rural Route Num	ber, City or T	own, State, Zip	Code)		
S Ô	and 2 fealth m 27 i		Jodi Yoes/niece	100, 5		Koko Lan	e Balt						
Baltimore, Maryland	Pages 1 tment of H tant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☒ Donation 5 ☐ Other (Specification)	Removal from State	emetery, cier	sition (Name of natory or other place		Date		ion - City or To			
Ba	permit Depar impor any in		Emm	Wade Director	Ва	Name and Addres ate Anato Iltimore,	MD 2	1201		imore S	treet		
		,	23a. Part 1. Enter the disease or com shock, or heart failure. List only		. Do not ent	er the mode of dying	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Bet Onset and I	ween	
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ASCVD  Due to (or as a consequence of):										
20	Examiner		Sequentially list conditions	, ATrial	Filler	Matroi							
1	ed sit	iner	Sequentially list conditions, it any, leading to instruction cause. Enter Underlying Cause (Disease or injury	Due to (or as a sone-gu	renou of).								
o Î	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequ	ience of):								
8760,	ate be hysicia the bur	lical		.d									
<u>ت</u> ×	certifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome pf pregna	nov.						-		
P.O. Box 6	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			230	I. Date of delive Month	,	Year .	
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the ur	nderlying cause give	n in Part I.			contribute to th			
Records,		Completed						24a. Wa aut per 1 Yes	opsy formed?	death?	osy findings and pletion of ca		
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Otho		Death (Check only					
ō	Phys er this eral dir	5. T	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		4 Marsi	ng Home 5 ☐ Re			′)		
io n	Attending Physician: r death. ector: After this certific: by the funeral director, I	atior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	28c. Injury Work M 1 ☐ Y	? ∕es 2∐No						
Division or Vital	ai or Atte s after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office			(Street and Nown, State)	lumber or Rura	l Route Num	ber,	
	To the Hospitai or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f	edical (	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	ne, date and pointion, death	place, and due to the	e cause(s) ar e, date and pl	d manner as st ace, and due to	ated. the cause(s	5)	
}	To t With To t	Σ	29b. Signature and title of certifier  All Tunil			29c. License	712-	7	3	igned (Month, i		8	
			30. Name and address of person who Di2 · A · AHME > 31. Date filed (Month, Day, Year) MAR 2 5 20	completed cause of death (Item	23a) (Type,	Print) St. Bal	timor	e MD	2120	/			
	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAR 2 5 20	32, Registrar's Signa	ture	ndi							

DHMH 17 Rev 1/2001

08-02 Diane	2252 e Vincent M	lcFa		<b>pe or Print in B</b> tate of Maryland				•	_			
			1- For State Registrar	-		cate of De		_	Reg	. No. 2	008	0943
	Physici	an/	Decedent's Name (First, Midd Diane Vincent	Mcfaddon					Date of Death     Month	Day Ye		Time of Death 1627 hrs
Med	ical Exami	ner	4a. Facility Name (if not instituti		•)	4b. Cit	v Town or lo	cation of Death	March 21, 2	4c. County	of Death	1027 1115
			Franklin Square Hos	-	,		sedale				re Coun	ty
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last bi			If Under 24Hrs.	8. Date of Birth	(MM/DD/YYY	y) 9. Birthr Foreign	place (State or
	Director		218-76-9585	1 M 2XF	51	Yrs. Mo	nths Days	Hours Min.	05/10/	1956		try) MD
	any	I	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Tow	n or Location					1	0d. Inside City Limits
	<b>*</b> 1		MD			nore Cit	У					1 XYes 2 No
	farylar 28a-f s at on	Director	10e. Street and Number			10f.	Zip Code		100	. Citizen of W	hat Countr	y?
	the M 3a or 2		852 Watson Str	reet			21202			USA		
	th with ems 2. t be no	eral	11. Marital Status  1 Never Married 2 X	12. Was Deceder Armed Forces				nic Origin? (Spe flexican, Puerto f			e - America te, etc.	in Indian, Black,
	er dea , or it r mus	Fun		1 Yes 2	2 X No	1 Yes	2 <b>y</b> No s	specify:		Specify:	Bla	ck
5	urs afl itural' amine	d by	15. Decedent's Education (Sp	or Dates:	mpleted) 16a	a. Decedent's Us	ual Occupation	(Give kind of w		16b. Kind of B		lustry
1	6 172 ho an "n; ical Ex	ompleted	Elementary/Secondary (0-12	) College (1-4 or		child Ca	-	O NOT use retire	ea)	Day (	are	
1	within giene.	omp	12 17. Father's Name (First, Middle	e Last)				Mother's Name	(First, Middle, M			
//	21215-0036 hould be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or items 23a or 28a-f show afte event, the Medical Examiner must be notified at once.	Be C	James Vincent	e, Lasty					ther We		•,	
	21; nould b d Men s mar tic eve	입	19a. Informant's Name/Relation			19b. Mailing Addr					wn, State, 2	Zip Code)
	MD and 2 sho alth and m 27 is aumati		Douglas Mcfado	den / Husband		352 Wats				21 ZUZ 20c. Location	City or T	our State
	ore, ges 1 an of He If ite		1 X Burial 2 Crematic	on 3 Removal from S	state crem	atory or other pla	ace)	02/2	27/2008			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygient Department of Heath and Mental Hygient was the statement of Heath and Mental Hygient share whateral", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other 3 21. Signature of Funeral Service		ML.	Carmel C		Υ	and the second			Home, PA
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	Box 68760, e death certificate be the attending physical for use as the bu	In/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome the 1 Live birth	ome of pregnand	cy 2 Fetal de	ath 3	Ectopic pregna	incy	23d. Date	of delivery Da	y Year
	ox 6  ath cer attendi	sicia	1 Yes 2 No 9 V U	mlum avum   '	at time of death	5 Other (	Specify)					
		Physician/Medical	Part II. Other significant cond	9 OTIKITOWIT	ath but not result	ting in the underl	ying cause giv	en in Part I.	23e. Did tol	pacco use con	tribute to th	ne cause of death?
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	of Vital Records,  ng Physician: The law requir  ther this certificate has been si nneral director, page 2 should t	e l	25. Was case referred to medic					f Death (Check of	only one)			
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	n of ding F h. After funer		27. Manner of Death  1 XX Natural 5 Per	28a. Date of In (Month, Day	njury 281 (Year)	b. Time of Injury	28c. Injury	at Work?	28d. Describe h	ow injury occi	irred	
	Division tal or Attendir rs after death. al Director:  Alled in by the fu	icati	2 Accident Inv	restigation 28e Place of	Injury - At home	, farm, street, fac			28f. Location (S	treet and Num	ber or Rur	al Route Number, City
	Divisior Hospital or Attend 24 hours after death. Funeral Director:	Certification:		uld not be termined (Specify)	. ,		,		or Town, St	ate)		
	Hosp 24 ho Fune etely f		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, o	death occurred a	t the time, date	and place, and	due to the cause	e(s) and mann	er as state	d.
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical		aminer:On the basis of ex	amination and/o d.	or investigation, in			it the time, date a			
	0 -	2	29b. Signature and title of certif				29c. License : O.C.M			March 22		th, Day,Year)
	W N		30. Name and addr ≠s of pers	who someted cause of	ath (Item 23s	a)						
*	OPOCME	8	Mary G. Ripple MD.	Deputy Chief Med			nn Street, I	Baltimore, M	1D 21201			
	<i>V</i> 3		31. Date filed (Month, Day, Year	r) 2. Registi	rar's Signature	1						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 09435 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year William Η. McNew. Jr. 23. 2008 6:50 /Medical March 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 106 South East Avenue Baltimore City If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 215-09-6258 90 Oct19,1917 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Md. Baltimore City 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 South East Avenue Funeral 21224 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No þ Specify: White 3. ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) 12th College (1-4or 5+) Longshoreman Shipping If item 27 is marked other or other traumatic event. the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. McNew, Sr. Emma Hurley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon McNew (daughter) 600 South Grundy St. Baltimore, Md.21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or once. St.Stanislaus Cem 3-26-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21 Signature of Funeral Service Licenses 1201 Dundalk Ave. Baltimore, Md. Toland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent, of): **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and Examir The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FFMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 52 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) stf 64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 350 STONI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

MAR 25

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM/9 11 12 15-22 per HT (878 47/08 WS)
State of Maryland / Department of Health and Mental Hygiene
Amend Items 24a, 25, 26, 27 per dr. 2877, 03/25/08dhb

Reg. No. 1 18 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Physician March 13, Charles Mobley 3:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) Aug 20, 1939 Washington, DC If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□F 68 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits work! ad other than "neturel", or Items 23a or 28e-f shovevent, the Medical Examinations at 1 ☐ Yes 2√ No Funerai Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20010 USA 1813 Wiltburger Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. -unk Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry -unk (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) <del>-unk</del>unk Salesman 12 Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk -unk ould be f Mental F Freddie Mae Mobley Charles Gant 9a Informant's Name/Relationship (Type, Print)
Grace Mobley/Wife
Washington Adventist Hospital ral Boute Number, City or Town, State, Zip Code) LOL Washington, DC 20024 and Health Important: If item 2: eny injury or other tr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Riverdale Crematory 4/3/08 '4 □Donation 5 NOther (Specify) in state Riverdale, MD S. Wade Director 21. Signature of Funeral Service Ronald 22. Name and Address of Facility string Royster Tuneral Hours a. Part. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. 14th Street, NV, Washington, IC 20011 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): cocci bacterenie Examiner 1051 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as the burial-transit and that initiated events resulting in death) Last Due to ( )r -s a consequence of): certificate be exec attending physician Physician/Medicai Box IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) \_ 1 ☐ Yes 2 ☐ No detached 9☐ Unknown o 9 Unknown ά ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Ą Records, рe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 🗌 Yes 1 Yes 2 🗆 No 2 No Vital in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel C Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 766 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 MAR 2 5 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 9.57 PM 3U4A3C MORTIMER MARCH 23,2008 Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Dec. 22, 5. Social Security Number If Under 24 Hrs. ace (State or Foreign 7. Age (In yrs. last birthday Maryland 1 M 2 K F Year) 927 Days 220-18-6007 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7578 Beach Rd 21122

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

Division or Vital Records, P.O. Box 68760,

land ow 1		10a. State	10b. County		10c. City, To	wn or Location					10d. Inside City Limits
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the 28a-	Director	10e. Street and Nu	l .			10f. Zip Code			10g. Citiz	en of What Co	ountry?
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within	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)	Inspector	euj		Wast	inghou	80
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Dis			20b. Place ceme	of Disposition (Name of tery, crematory or other p	lace)	Date	20c. Loc	ation - City or	Town, State
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/Medical		resulting in death)			a consequenc						- Chiles
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Physician: rr this certific rral director,	To E	examiner? 1 ☐ Yes 2 🛣	No	Hospital: 1 🔀 Inpatio	ent 2 ER/0	Outpatient 3 DOA	Other: 4 Nursing	Home 5 ☐ Resi	idence 6	Other (Spe	ecify)
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	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Year  3. Time of Death
100	/Medic Examir	al	4a. Facility Name (If not institution, give street and number)	Miller March 19 2008 1619 M  4b. City, Town, or Location of Death  4c. County of Death
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)  1□ Yes 2□ No Specify:  14. Race - American Indian, Black, White, etc.  Specify: □ Inite
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Š	1 and 2 Health a tem 27 is		Connie M. Miller (spouse)	1443 Pennsylvania Avenue, Pine City, NY 14871
nore	Pages 1 Tent of H Int: If iter		1 X Burial 2 □Cremation 3 □Removal from State	Place of Disposition (Name of cemetery, crematory or other place)  Place of Disposition (Name of cemetery, crematory or other place)  March 24  Coc. Location - City or Town, State  Gillett, New York
Baltimore,	permit. P Departme Importan any Injury once.		4 □ Donation 5 □ Other ( <i>Specify</i> )  21. Signa ure of Funecal Service Licensee	entley Creek Cem. 1 2008   Gillett, New York  22. Name and Address of Facility Stallings Funeral Home, P.A.
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O. Box	the death y the atter iched for u	hysician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown	etal death 3 Ectopic pregnancy Month Day Year
rds, P.	The law requires that the death certificate be executed the has been signed by the attending physician and Kape 2 should be detached for use as the burial-transitions.	by P	Part II. Other significant conditions contributing to death but not i	esulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	rhe law re te has bee age 2 sho	Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 1 No 1 □ Yes 2 □ No
Ital		Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
	<b>Phys</b> this al di	은	27. Manner of Death 28a. Date of Injury	□ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)  28b. Time of 28c. Injury at 28d. Describe how injury occurred
ion	Attending Physician: r death. ector: After this certifics by the funeral director, I	ation	↑ Natural 5 □ Pending (Month, Day Year 2 Accident investigation	28b. Time of Injury M 28c. Injury at Work? 2 No 28d. Describe how injury occurred
DIVISION OF	al or Attending I safter death. Il Director; After d in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - A building, etc. (Spe	home, farm, street, factory, office cify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my left of the control of	nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	1		30. Name and address of person who completed cause of death (!	RES-000 March 19 2008
	5		Clinton D Kema M D 6	00 North Wolfe Street Baltmore MD 21287
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Si	nature

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrer	S	tate of N		-		of He	ealth a		ental Hy		111175	09439
	a .		1. Decedent's Name (First, Midd	le, Last)								2. Date of De	ath Dav	v Year	3. Time of Death
	Physici /Media		Ruth	Murph	ny		Nel:	son			N	larch		2008	12:30 P <sup>M</sup>
	Examir	79	4a. Facility Name (If not institution					4b. City, To	own, or	Location o	f Death		4c.	County of Death	
			Washington Adv	entis	t Hosp	ital		Takom						ontgomer	
	Funeral		5. Social Security Number	6. Sex	2 F 7		last birthday) Yrs.	If Under 1 Months	Year Days	II Under 2 Hours	Min	8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State or Foreign ntry)
ı.	Director		250-22-0860 Usual Residence of Decedent			85	115.					July 1	o, 1	922 Sout	h Carolina
	land ow		10a. State 10b. County	,		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary Hish	tor	Maryland Prin	ce Geo	orge's	Up	per Ma	rlbor	)						1 ☐ Yes 2 🔀 No
	r 288	Director	10e. Street and Number					10f. Zip C	ode				10g. Cit	izen of What Cou	ntry?
	h witi 23e o 31 be		7823 Locris Dr	ive				207	72				U.S	.A.	
	or death with the Marylar tems 23e or 28a-f show er mat be rediffed at	Funeral	11. Marital Status	12.	Was Decede Armed Force	nt Ever in U.	.S. 13.	Was Decede	nt of His	panic Orig	gin? (Spec	cify Yes or No lican, etc.)	)-	14. Race - Ameri Black, White	
98	or it		1 Never Married 2 Ma	ried	1 Yes 2 If Yes, Give	Νo		1 ☐ Yes 2[			, , , , , , , , , , , , , , , , , , , ,	,	ĺ	0	
8	72 hours afte "neturel", or it	d by	3 ¼ Widowed 4 ☐ Divorce	1	Year or Date	\$:								PT	ack
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12	filed withi Hygiene. other then	ш	Elementary/Secondary (0-12)		College (1-4d	or 5+)		memake					(	Own Home	
9	Hyg Hyg		17. Father's Name (First, Middle	Last)			110	me marc		18. Mothe	r's Name	(First, Middle			
lan	a ta b	To Be	Moses Murphy							Mode	ly Ja	ckson	Murp	hy	
Maryland 21215-0036	2 should and Men is marke eumetic		19a. Informant's Name/Relation	ship (Type,	Print)		19b. Mailir	ng Address (	Street a	nd Numbe	r or Rural	Route Numb	er, City o	or Town, State, Zi	c Code)
	rtr		Christine Bla	ke (I	Daught						per	Marlbo	ro,	MD 2077	2
ore	es 1 au of Hez f item ir othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Rem	oval from Sta	20b. P	lace of Dispo emetery, crei	sition (Name natory or oth	of er place		Da		20c. Lo	ocation - City or T	own, State
Ĕ	Pag ment ent:		'4 □Donation 5 □ Other (.	Specify)	)	Jef	fersor		and the same of th		-21-0			tsburgh	, PA
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ott		21. Signature of Funeral Service	Licensee	11		22   	Name and Robert	Address A.	Wate:	rs Fu	neral	Home	e DA	1 5 1 2 2
	_		23a. Part1. Enter the disease, of	r complicati	ions that caus	ed the deat								ort, PA	Approximate
	Pnysician		shock, or heart failure. Lis Immediate Cause (Final	t only one c	ause on each	i line.	15								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	Due to (or	as a conseq	uence of):		_	M			. 4		
	Examiner		Commentally line and deline	b. —	0	Lost	ridi	um	Di	1	all	re Co	Cet	25	
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>)</b> "	Due to (or	as a conseq	uence of):	1		2	1	1		100	
	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	aa	w	re	na	_	pai	lu	N.C.			
,092	ite be executed lysician and ne burial-transit	cal E	rosalling in doubly East		Due to (or	as a conseq	uence of):								
687	e K			d											
Box 6	death certificat e attending phy of for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		If yes, outcor									23d. Date of deliv	erv
	death e atte	iclai	in the past 12 months?		1 Live birth	at time of d		Ectopic pred Other (spec						Month	Day Year
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s, P	The law requires that the ste has been signed by the bage 2 should be detache	by P	Part II. Other significant condit	ons contrib	uting to death	but not res	ulting in the u	nderlying cau	ise give	n in Part I.					the cause of death?
ord	w require been sign											1 🗆	Yes 2	□No 3□Pro	bably 4 Dunknown
Vital Record	e law re has bei ge 2 sho	Completed										24a. Was	osy	24b. Were aut	opsy findings available ompletion of cause of
- E		Con										perfo 1☐ Yes	rmed? 2  No	death?	2 No
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	_	itali an				0.0			(Check only			
of	Phys this al dii	5	1 Yes 2 No	Hosp	141 Inpa		ER/Outpatier							6 Other (Special	fy)
	ding h. After fune	tlon	1 X Natural 5 ☐ Pendi	ng igation	28a. Date of II (Month, I	Day Year)	Injury	M 200	Work'	ai ? ′es 2∐1	i	8d. Describe	now inju	ry occurred	
Division	of or Attending after death. Director: After din by the fune	ertification;	3 ☐ Suicide 6 ☐ Could	not bo	28e. Place of	Injury - At ho	ome, farm, str					8f. Location (	Street an	nd Number or Rur	al Route Number,
Ω̈́	el or / s after il Dire	Certi	4 Homicide	mied	28e. Place of building,	etc. (Specify	y)	. ,.				City or To	wn, State	9)	
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical (	29a. Certifier (Check only one) Certifyi	ng Physicie Exeminer:	On the basis	of examina	wledge, deat tion and/or in	occurred at vestigation, in	the time	e, date and inion, deat	d place, ar	nd due to the d at the time,	cause(s	) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certific	er	and manner	stateu.		29c.	License	number			29d. Da	te signed (Month	Day, Year)
	⊢ s ⊢ ŏ		> Man	ma	24	, n	J)	7	66	156	1		31	11/10	2
	1		30. Name and address of persor	who compl	leted cause o	of death (Item	n 23a) (Type,	Print)			-			1610	)
-	~	151	Van Mi	21	76	00 Car	roll A	ve.,	Γako	ma Pa	ark,	MD 200	12		
ţ. ş	Sta		31. Date filed (Month, Day, Year			strar's Signa		0 4 M 2							
<b>1989</b>	Registr	ar	MAR 2 5	2008	John John	ias L	J. 19	To the second							

/M Fune Direc Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Physici

Division or Vital Records, P.O. Box 68760,

For

22 , 2008

		1 - State Registrar					Ce	rtificat	e of	Deat	h		Reg. No.	2000	0 9 4 4 6
Physicia /Medic		1. Decedent's Name (First, Midd Wilkie	dle, Las	t)		N	anan					2. Date of D Month MARCH	eath Dav		3. Time of Death
Examin		4a. Facility Name (If not institution		_	ımber)				_	or Locatio	n of Death	1114		County of Death	
Funeral Director		Union Memoria  5. Social Security Number  219-43-8208	6. Se		7. Age	(In yrs. la	as <i>t birthday)</i> 5 Yrs.	If Under			er 24 Hrs.	8. Date of Bi (Month, D	ay, Year)	9. Birth	place (State or Foreign ntry) D, Trinidad
pur		Usual Residence of Decedent 10a. State 10b. Count	v			10c City	, Town or Lo	cation							10d. Inside City Limits
Aaryla shor	ō	Maryland Balti		Δ		roc. Oity	Dunda								1 ☐ Yes 2 No
the A	Funeral Director	10e. Street and Number	IIIOI					10f. Zip	Code				10a Citi	zen of What Cou	nto/2
with 3a or t be		6802 Dunbar Roa	Бе						1222				US		nuy:
ms 2;	Dera	11. Marital Status	1	12. Was Dec	edent_E	ver in U.S	6. 13.				Origin? (Spe	ecify Yes or N Rican, etc.)		14. Race - Ameri	can Indian,
al", o	र्व	1 ☐ Never Married 2 💢 Ma 3 ☐ Widowed 4 ☐ Divorce		Armed Fe 1 ☐ Yes if Yes, G Year or D	2 📉 N	lo		lf Yes, spe 1 □ Yes		Specia		Rican, etc.)		Black, White, Specify: Wes	<sub>etc.</sub> t Indian
72 hou	Completed	15. Decede	nt's Edu	ucation		- 1	16a. Dece	dent's Usu	al Occup	oation			16b. Ki	nd of Business/Ir	dustry
thin 7 e. an "r Med	Be	(Specify only high Elementary/Secondary (0-12)	est grad	College (	1-4or 5-	+)	life.	DO NOT u	rk done se retire	during m d)	ost of worki	ng			
ed wi ygien er th t, the	ទូ	12 years					We.	lder						oats	
be fill d oth even	Be	17. Father's Name (First, Middle										(First, Middle	e, Maiden	Surname)	
ould Mer Jarke	၉	Decanaicine Nar					1				y Nan				
und 2 sh alth and 27 is n	- 1	19a. Informant's Name/Relation Conrad Nanan	ship (7)	son								alk,Ma:		r Town, State, Zij nd 2122:	_
ss 1 a		20a. Method of Disposition				20b. Pla	ace of Dispo	sition (Nai	ne of other plac	ce)	Marc	nate 27,	20c. Lc	cation - City or T	own, State
Page nent ant: If		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (			State	l .	view (	,	,	· ·	200		Balt	imore C	ity, MD.
Departi Departi Mporta any Inji		21. Signature of Funeral Service	e Licens	see /	n 1	00	(), (č	Name ar	d Addre	ss of Fac	al Ho	me Of I	Dunda	ılk,P.A.	
		23a Part1 Enter the disease	T comp	lications that	raused	the death								lk,Md.	
Physician /Medical Examiner		23a. Part1. Enter the disease shock, or heart failure. Is Immediate Cause (Final disease or condition resulting in death)	only o	a.Con	00	EST conseque	Ence of):	HE	AR-	TF	AIL	URE		Dracas	Approximate Interval Between Onset and Death
ate be hysicia the bur	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	l	AMI	20	RONSeque	ence of):	_		I					3 mouth
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			birth at	of pregnan 2  Fetal time of de	death 3	Ectopic pi Other (sp		у				23d. Date of deliv Month	ery Day Year
res the igne	2	Part II. Other significant condit	ions co	ntributing to d	eath bu	t not resul	ting in the u	nderlying c	ause giv	ren in Par	t I.				he cause of death? pably 4 Denknown
	Completed											24a. Was auto perf 1 Yes		prior to co	opsy findings available mpletion of cause of 2 No
certif ector	g n	25. Was case referred to medic examiner?	· -	Hospital:					Oth		ce of Death	(Check only	one)		
this ld	<u> </u>	1 Yes 2 No	1.	28a. Date	of Injun		R/Outpatier 28b. Time of		Α	4⊔1				6 □Other (Speci	(y)
ath. or: After	Certification:	1 Natural 5 ☐ Pendi	igation	(Mon	th, Day	Year)	Injury	М		k? Yes 2[		28d. Describe	now injur	y occurred	
s after death	TITLE C	4 Homicide determ		28e. Place build	of injur	ry - At hon . <i>(Specify)</i>	ne, farm, str	eet, factory	, office				(Street an wn, State		al Route Number,
To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Phy i Exam	sician: To the ner: On the b and man	asis of	examinati	rledge, deatl on and/or in	n occurred vestigation	at the tir , in my c	me, date opinion, d	and place, leath occurr	and due to the ed at the time	cause(s) , date and	and manner as s I place, and due t	stated. to the cause(s)
To th To th comp	Me	29b. Signature and title of certific	ər					290	Licens	e numbe	r		29d. Dat	e signed (Month,	Day, Year)

State Registrar AMIRA MOHAMMED 31. Date filed (Month, Day, Year) MAR 2 5 2008

DAMIRA MOHAMMED SIYAM, MD

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

AT 2438946

STYAM, M.D. UNION MEMORIAL HOSPITAL, BALTIMORE, MD

1	_	For State
	_	Registrar

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			1 - State Registrar		,	Ce	rtifica	te of I	Death	,	,	Reg. N	lo.		
tiş	Dhunini		1. Decedent's Name (First, Middle	e, Last)							2. Date of De	eath	ay	Year	3. Time of Death
	Physici: /Medic		Sarah Virginia	Pinnix							MARC	H	EB,	2008	04:34FM
	Examin	er	4a. Facility Name (If not institution Saint Jose			ter	4b. City	Town, or	Location	Tows				y of Death Balt	imore
	Funeral Director		5. Social Security Number 213-20-9646	6. Sex 7. 1 ☐ M 2 1 F	Age (In yrs. I	as <i>t birthday)</i> Yrs.	If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 1	th ay, Yea 2,1	925	Cour	place (State or Foreign ptry) IMORE, MD.
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation							1.	0d. Inside City Limits
	e Maryla 3a-f shov tified at	Director		more Count		ltimor									1 □Yes 2ŽNo
	with th	Dire	10e. Street and Number	ro.			10f. Zi	o Code	21212			_		What Cour 3 Sta	•
	eath v	Funeral	724 Regester Av	12. Was Decede	ent Ever in U	S 13	Was Dece				ecify Yes or No			ce - Americ	
326	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Force ried 1 ☐ Yes 2 If Yes Give	es? L∐ No		lf Yes, spe 1 ☐ Yes				ecify Yes or No Rican, etc.)			ck, White,	
ž	72 hou	ted	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usu	al Occup	ation	ot of warki	ing.	16b.	Kind of B	lusiness/In	dustry
Maryland 21215-0036	within 7 jiene. r than "r the Med	Completed	Elementary/Secondary (0-12)	College (1-4 n/a	or 5+)		<i>bö nöt?</i> gael			st of workii Y	ng		Li	aw Fi	rm
ם	al Hyg	BeC	17. Father's Name (First, Middle,	·							(First, Middle	, Maide	en Surnar	me)	
<u> </u>	ould b Ment arked atic e	70	James Henry Cos			1				James					
<u>aa</u>	C/ 10 - 10		19a. Informant's Name/Relations Mrs. Valerie Sp		abter)	1	ng Addres Gers				al Route Numb Cy Hall	-			Code) 21128
ď	1 and Health em 27	9	20a. Method of Disposition	encer (Dau	20b. P	lace of Dispo	sition (Na	me of			Date			- City or To	
) E	ages ent of it: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate C	emetery, crei	matory or	other plac	, ,	arch	25,08			-	l,Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service		101-	// 2	2. Name a	nd Addres	ss of Facil	ity	- France	1	C Class		. Chr. D %
ñ	an Dec		1 Then	7 7 1	ruse,		aceri 325	York	Road	ative	s Fune Cimoniu	raı m,M	aryl.	and	n Ctr., P.A 21093
			23a. Part . Ent . the diseas . shock, or heart lilure. Lit	complications that so only one cause on	sed the death th line.	n. Do not ent	ter the mo	de of dyin	g, such as	s cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	MONIA										Oriset und Deuti
	Examiner		,		as a consequ NIC O		CTIV	E PI	ULMO	NARY	DISE	ASE	Marie Marie		
	4 -	Jer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	as a consequ			-			JOSP ING SALLY SUMM	1 400 80	-		
30	cuted nd rransit	Examiner	Cause (Disease or injury that initiated events	c											
کر'	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or	as a consequ	uence of):									
68/6N,	physics the the control of the contr	Medical		d											
×	death certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregna	ncy							23d. Da	ate of delive	ery
.O. Bo	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1∐Live birt 4□Pregnar 9□Unknow	h 2 ⊡ Fetal nt at time of de n		⊒Ectopic p ⊒Other (s			-				onth	Day Year
ΛŲ.	w requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditi	ons contributing to deat	th but not resu	ılting in the u	nderlying	cause give	en in Part	I.	23e. Did 1	tobacco	use con	tribute to t	ne cause of death?
ecords	equire en sig ould b	ted k	ALCOHOLISM								1 🗆	Yes	2 <b>☑</b> No	3 ☐ Prot	ably 4 Unknown
င္တ	law r las be	Completed									24a. Was	DSV	24b.	Were auto	psy findings available mpletion of cause of
	sician: The lav certificate has rector, page 2										perfo 1□ Yes	ormed?	No	death?	
VII	Physician: r this certific ral director,	Be	25. Was case referred to medica examiner?  1 ☐ Yes 2★ No	Hospital:				Othe	ar:		(Check only o				
Ö	g Physer this eral di	5	27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		28c. Injur Worl	4 🗆 10		me 5 Resi				y)
0	ath. rr: Aft	atio	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	9 '	Day Year)	Injury	м		<br Yes 2 □	]No					
DIVISION	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of building	finjury - At ho , etc. (Specify	me, farm, str	eet, factor	y, office		2	28f. Location ( City or To	Street a	and Numi ite)	ber or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Medical C	29a. Certifier  (Check only one)  1 Certifyir  2 Medical	ng Physician: To the be Examiner: On the bas and manne	is of examinat	wledge, deat tion and/or in	h occurred vestigatio	at the tir	ne, date a pinion, de	ind place, a eath occurr	and due to the red at the time	cause , date a	(s) and m	nanner as s , and due t	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certific	4	11	N	29	c. License	e number			29d. E	ate/signe	ed (Month,	Day, Year)
			· (not	4 tou	$M_{I}$	V.		D240	234			2	>/2	3/0	8
	5		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)							1	
		10	31. Date filed (Month, Day, Year)	M. D. 761	ZI OSL Histrar's Signat		RIVE	TO	NOON.	. MA	RYLAN	DE	2120	4	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Da Physician 9 2008 March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia on Huspita Count unard If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 10 • 19 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City Town or Location 10a. State 10b. Count 1 Yes 2 □ No Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USF Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maid Be 2 s (Street and Number or Rural 19b. Mailing Adeh permit. Pages 1 and 2 Department of Health a Important: If item 27 is acqueline Wumbia 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21, Signature of Funeral Service License Vaugh C. Steine 5151 Balto. Nat'l Pile (23a. Partl. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 Balto. Approximate Interval Between Onset and Death Immediate Cause (Final ocardi **Physician** Luurs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner UD C Sequentially list conditions, Due to (or as a nonsequence of) any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 🗌 Yes 2 ER/Outpatient 3 □ DOA 2 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 00038026 008 . -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cedar 5755 King .0

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32. Registrar's Signature

1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Year **Physician** 35 PM ENNEPACKER MARCH 2003 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Horkins Bayview melicial centel TIMORE If Under 1 5. Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 □ F 219-30-3270 73 October Director Pennsylvania 12,1934 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Baltimore Edgemere Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21219 USA 10 Elinor Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Wes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White ò 3K Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Eastern Stainless Inspector 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Pennepacker Luella Breon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter 819 Cedar Avenue, Essex, Maryland Donna Frank 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 25. 20a. Method of Disposition 1 ☐ Burial 2 ② remation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 12 9K /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and The law requires that the death certificate be executed physician and X sthe burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 2- ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oxkins boyview Medical Conte

State Registrar 80

31. Date filed (Month, Day, Year)
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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** A W Warth 0714 maron 0 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center nk 6. Sex 7. Age (In yrs. last birthda University of M 5. Social Security Numberunk 9. Birthplace (State or Foreign Country) unk 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 60 Director Sept 16, 1947 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d Inside City Limits 28a-f show "natural", or Items 23a or 28a-f sl edical Examiner must be notified Director 1X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21223 USA 1204 Glydon Avenue Funeral unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: white **∂** 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation unk traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) un 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) Be P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl
Department of Health an
Important: If Item 27 Is r
any injury or other traur 22 S. Green Street Baltimore, MD University of MD Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5 NOther (Specify) in state Wade State Anatomy Board 655 W. Baltimore Street konald Director Baltimore, MD 23a. Pat1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Distress Syndrome Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed Exami Influenza burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as 1 IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 21 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) led by the a detached f P.0. 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P After this Date of Injury (Month, Day Year) he Hospital or Attending Pl n 24 hours after death, he Funeral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Baltman, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day /Medical Sadie Peake March 17 2008 10:15 AM 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗹 F Director 91 215-10-4593 Jan 31, 1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov :dical Exaπiner must be notified at MD Director Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5631 Belle Avenue 21207 within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white ð 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) food preparer food industry h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Gerber Lena Rubinstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 le other tra Doletta G. Taylor-Thomas/daughter 5631 Belle Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important; If its any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∭Donation 5☐Other (Specify) 21. Signature of Funeral Sept ce Licensee
Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Part . Enter the disealle, or of implicational hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER 30 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Day Ö 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed' Vital Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specity) 1+05 PICE 1 ☐ Yes 2 ☐ No 1 🗍 Inpatient 2 ER/Outpatient 3 DOA Certification: To 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident investigation 1 Tes 2 No 24 hours after death Puneral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 111 3.17.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200p Eleanor Mary Rothermel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore sood Sementer Baltimore MD21239 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 4 Hours **Director** 82 Md. 216-20-4103 12-11-1925 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 17√TYes 2□No Director Md. Baltimore, Md. 10f. Zip Code 21213 10e Street and Number 10g. Citizen of What Country? ortant: If Item 27 Is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be I USA 3624 Elmora 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill lealth and Mental H Im 27 Is marked oth Be Andrew Poturalski Veronica Paitys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 Is any injury or other trau Ronald Rothermel 9309 Ravenridge Rd. Parkville, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-25-2008 St. Stanislaus Dundalk, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Die Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiocenic **Physician** /Medical Due to (or as a consequence of): Examiner Oncesti be Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of): Examiner Ulmonoor burial-tran Due to (or as a consequence of) be exe Box 68760, attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9☐Unknown 9 Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Fitn Eletion 1 ☐ Yes 2 4 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an this certificate has autopsy ormed? 2**⊈N**d Was case referred to medical examiner? 1∐ Yes Division or Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 [ Q N 1 4 Impatient P 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Hospital or Attending 1 ANatural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide after 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours aft To the Funeral Di completely filled in the To the

State Registrar

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Prin.) 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Bld Good Remeritan Hospital ICLI 32 Registrar's Signature

resident

29d. Date signed (Month, Day, Year)

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Registrar

32 Registrar's Signat

29c. License number

29d. Date signed (Month, Day, Year)

	02184 nathan Dew	ayne	1- For State Certificate of Death
	Physici		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year
N. C.	al Exami	iner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
-			2310 Tarleton Lane #C Parkville Baltimore County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
	Director		414-96-1426 12M 2 F 32 Yrs. Will Dec 30, 1955 Country) TN
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	ınd show :	٦c	Maryland Baltimore Baltimore 1 - Yes 2 ANO
	Maryla 28a-f dator	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		2310 Tayleton Lane Apt C 21234 United States
	eath wi items ust be	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	after d al", or	by Fι	3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: Specify: Specify: Specify:
	hours 'natur	ed k	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
N	36 hin 72 e. than "	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Nurse's Assistant Hospital
W	nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene.  It: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Con	17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname)
4.	2121 uld be fi Mental J marked c event,	Be c	John Robinson Mattie Brown
/	MD 2 12 shoul th and M 127 is m umatic	ပို	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Ammie L Robinson - Brothor 23/10 Tax Lefon Lane Apt C Billio, WD 21234
	e, N 1 and 3 Health item		20a. Method of Disposition
	Pages Pages nent of tant: If		1 Burial 2 Cremation 3 Removal from State Cremetory or other place) 4 Dopetion 5 Other Specify:  A Dope
	Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams (5.5, R.4,
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate interval
(	Medical		failure. List only one cause on each line.  Between Onset and Death
المدد	≟xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
		ē	Sequentially fist conditions, if any, leading to immediate Due to (or as a consequence of):
		amine	Cause. Enter Underlying Cause (Disease or injury that initiated
V	d tted		events resulting in death) Last  Due to (or as a consequence of):  d.
	e executian and ial - tr	lical	X UNPENDED AMENDED 1,23a,27 per ME g878 4/3/08 amh
	760, icate be physic the bur	an/Medical E	IF FEMALE:  23c. If yes, outcome of pregnancy  23d. Date of delivery  23b. Was decedent pregnant in the  4 July high  April 1 July high  April 2 J
	Box 68760, e death certificate b the attending physical for use as the bu	cian	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
	BOy e death the att	Physicia	1 Yes 2 No 9 Unknown 9 Unknown
	n of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burnal - transi	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
	ds, Faures sen sign	ted	24a. Was an 24b. Were autopsy findings available
	COFC law re has be e 2 sho	Completed	autopsy prior to completion of cause of performed? death?
	I Re n: The tificate or, pag		25. Was case referred to medical 26.Place of Death (Check only one)
	Vita ysicia this cer direct	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other; 4 Nursing Home 5 Residence 6 ✓ Other: Scene
	Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	n: T	27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
	Sior Attend death ector: by the	catic	2 Accident Investigation
	Divi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
7	Hospi 24 hou Funer tely fil		4 Homicide 1990. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
0	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O. C.M.E.  March 19, 2008
			O THE O
	0		30. Name and address of person who complèted cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

08-0	2292
Eric	Rife

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 191,49 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 23, 2008 Medical Examiner Rife 1033 hrs Eric 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Baltimore 9. Birthplace (State or Foreign **Funeral** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) Davs Phoenixville, PA Director 181-52-1833 December 27,1971 1 XM 2 F 36 Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 XNo Anne Arundel Brooklyn 28a-f show Maryland with the Maryland Director 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21225 USA 124 W. Meadow Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces' White, etc. 2 X No Yes White Yes 2X No specify. 4 X Divorced Widowed Yes, Give Yea Specify à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tant: If item 27 is marked other than "natur or other traumatic event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. Department of Health and Mental Hygiene. Medical Occupational Therapist 12 years 4 years 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Reginald L. Rife Be Alice C. Morris 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald L. Rife Father 230 Beacon Drive, Phoenixville, PA. 19460 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State March 28 crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. Ann Cemetery 2008 Phoenixville, PA. Important: Donation 5 Other Specify Signature of Funeral Service Licenses <sup>22</sup>Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and edical Death Cardiac Arrhythmia Due to Cardiane aly Immediate Cause (Final disease a xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical AMENDED 23a,27 per ME g878 4/21/08 amh X UNPENDED ending physician use as the burial The law requires that the death certificate be Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown a Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 No 1 V Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 this DOA Nursing Home 5 Residence 6 Certification: To 1 V Yes No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Yes 2 No Pending 24 hours after death. To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number March 24, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

**ÖRIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Mildred M. Roberson 2008 19, 9:10 PM March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan. 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🔀 F 85 Yrs 404-22-1723 1923 Kentűcky Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 Thames Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2克 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 Clerk Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julian Marshall Mattie May Ritchardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2009 David Roberson Son 1801 Clydesdale Pl., Unit 207, NW Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restnaven 20a. Method of Disposition Date 20c. Location - City or Town, State March 24 1 X Burial 2 ☐ Cremation 3 □Removal from State 2008 Frederick, Marvland 4 ☐ Donation 5 ☐ Other (Specify) <u>Memorial Gardens</u> 21. Signature of Funeral Service Licensee Name and Address of Facility Sthaven Funeral Services, Skkot Cody P.A. 9501Catoctin Mtn. Hwy. Fredérick, MD 21701 23a. Parti. Er in the disease, per emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. Let only one cause on each line.

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu

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Baltimore,

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Funeral

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Be Completed

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death with the Maryland

/Medical

10a. State

Division or Vital

O Records, Veson.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

	Immediate Cause (Final disease or condition resulting in death)	a. Intracerel Due to (or as a consec	oral Henry	orhage			- Onset and Death
L	Sequentially list conditions.	b. Hypertens:					
ical Examiner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of 0	al death 3 ☐Ectopic			23d. Date of de Month	livery Day Year
호	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ed by					1 ☐ Yes	2 <b>∑</b> No 3□P	robably 4  □Unknown
Completed					24a. Was an autopsy performed? 1  Yes 2	death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?				ath (Check only one)		
2	1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpatient 2 □	ER/Outpatient 3 [	OOA Other: 4 Nursing F	fome 5 ☐ Residence	6 □Other (Spe	cify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rate)	ural Route Number,
dical (	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)

29c. License number

8600 Old Georgetown Rd., Bethesda, MD 20814

29d. Date signed (Month, Day, Year) March 20. 2008

29b. Signature

Natasha Haag,

31. Date filed (Month, Day, Year)

MAR 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

M.D.

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RUSSFLL ELLIOT MARCIT 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Oct 18, 1918 7. Age (In yrs. last birthday) **Funeral** Months Days 1 **∑** M 2 □ F Yrs. Director 081-12-3836 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at show Howard 1 ☐ Yes 2√ No Director Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 11674 Little Patuxent Parkway 21044 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. by Funeral 12, Was Decedent Ever in U.S. Acmed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 142-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) architect landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raphael Rosenberg Estelle Goldstein ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Russell/spouse 11674 Little Patuxent Parkway Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation & ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Ignatore el Funda S Rona I o mon Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PHEUMUNI **Physician** /Medical Due to (or as a consequence of): Examiner 4510M40 Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed Churic Obstructive attending physician and for use as the bunal-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 4☐Pregnant at time of death I□Yes 2□No 9 ☐ Unknown Part Il Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completely filled in by the funeral director, p

State MAR 25 Registra

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH GEH, and 21801.

PLI SUITE 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Juanita Μ. Rose March 20, 2008 17:43 /Medical 4c. County of Death 4b. City, Town, or Location of Death Clinton 4a. Facility Name (If not institution, give street and number) **Examiner** Southern MD Hospital Months Days Hours Min. 0 7 - 0 8 - 1 9 3 6 Social Security Number 013-26-6025 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**K** F Texas Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits DC Washington 1 ☐ Yes 2 TNo Director 10f. Zip Code 20020 3619 Austin St. 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo 1 ☐ Yes 2 Ho Specify: Specify Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillie Barnes Baspard Barnes ပ 19a. Informant's Name/Relationship (Type. Print) George W. Rose/ Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3619 Austin St. SE Wash. DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico Nat'l Cem 4-1-08 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Triangle, VA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II FA 108 W. North Ave. Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,  $_{\mathscr{A}}$ that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): ending physician and use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No s certificate has the irector, page 2 s To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 **1**No 2 NER/Outpatient 3 DOA hours after death.

Ineral Director: After this
Iv filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 10 dress of person who completed cause of death (Item 23a) (Type, Print) UNE CONTER WHALMONF, MICH. 201002 12070 OU

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

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egistrar's Signature

	)2248 nalyn D. Rus	sell		or Print in Blacte e of Maryland / D		f Health				Management of the Control of the Con	3 0945
	Physic	an/	Registrar  1. Decedent's Name (First, Middle,L		Certificate 0	Death		R. 2. Date of Dea	eg. No.		3. Time of Death
Me	dical Exam		Tamalyn	D. Russe	ell			Month March 21,			0931 hrs
4			4a. Facility Name (if not institution, a 592 A Street	ive street and number)		4b. City, Towr Pasader	n, or Location of Deat	h	4c. County of Anne Aru		
	Funeral			Sex 7. Age (In	yrs. last birthday)	If Under 1		s. 8. Date of Bir			nplace (State or Foreign
	Director		217-78-9320 1	M 2 XF	40 Yrs	Months .	Days Hours Min	2	6/1967		ntry) MD
	ń		Usual Residence of Decedent					0370	107 1007		
	re Maryland or 28a-f show any fied at once		10a. State 10b. County Maryland Ceci		City, Town or Loca	tion	Earlevill	0			10d. Inside City Limits  1 Yes 2 No
	aryland 8a-f sh at onc	Director	10e. Street and Number			10f. Zip Coo			0g. Citizen of Wha	t Coun	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once,		195 Cullen Dri	ve			21919			USA	•
	th with ems 23 t be no	Funeral	11. Marital Status  1 Never Married 2 X Marri	12. Was Decedent Ever			f Hispanic Origin? ( Suban, Mexican, Puerto		14. Race - White,		an Indian, Black,
	er deal			1 Yes 2 X				o raiodii, oto.,			ite
1	ours aft ttural' amine	d by	15. Decedent's Education (Specify	or Dates:	ed) 16a. Deceder	nt's Usual Occ	No specify: upation (Give kind of		Specify: 16b. Kind of Busi		
Or	6 172 hc an "nz cal Ex	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	_	life. DO NOT use re	tired)			
1	-003 I within giene. her th	Completed	12 17. Father's Name (First, Middle, La	et\		Homem		o (Einst Middle	HOU:	seho	old
1	215-003 be filed within ntal Hygiene. rked other the	Be C		wisher			Linda		encer		
	21 hould I nd Mer is mar	Tol	19a. Informant's Name/Relationship	(Type, Print )	19b. Mailin	g Address (S	Street and Number or	Rural Route Nur	mber, City or Town	, State,	Zip Code)
	, MD and 2 sho ealth and em 27 is raumati		Kenneth W. Russ 20a. Method of Disposition		2) 195 20b. Place of Dispos		Drive, Ea	arlevill Date	e. MD 219		Four State
	Baltimore, permit. Pages 1 an Department of Hea Important: If ite njury or other tr.		1 Burial 2 X Cremation	Removal from State	crematory or of	her place)	Mar	rch 24 2008			
	nit. Partmer artmer sortant		4 Donation 5 Other Spec 21. Signat le of Funeral vic Lib	fy: ensire	Metro Cre		1110.				Maryland
_	Dep Der		lan .	7		3111 M	lountain Ro	bad, Pas	adena. M	D 2'	ome, P.A. 1122
	Physician /Medical		23a. Part I. Enter the 1 sease, or confailure. List only one cause on	eath / ne.					est, shock, or hear	t	Approximate Interval Between Onset and
4,	xaminer	Н	Immediate Cause (Final disease or condition resulting in death)	a. Complications  Due to (or as a consequence)		Body Puli	monary Throm	boemboli			Death
			Sequentially list conditions,	b							
		ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.	nce of):						
	sd sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
	executed an and al - transi		X UNPENDED	dAMENDED23a,27,	non ME -070	1./20/00					
		Medi	IF FEMALE:	23c. If yes, outcome of		4/ 20/ 00	aliti		23d. Date of d	elivery	
	Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	sician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	2 Fe	tal death	3 Ectopic pregn	ancy	Month	-	ay Year
	Box death he atter d for u	ysic	1 Yes 2 No 9 V Unknow		or death 5 O	ther (Specify)					
	P.O. es that the igned by to detache	by Phy	Part II. Other significant condition	contributing to death but	not resulting in the	underlying cau	ise given in Part I.			_	he cause of death?
	ords, P.O.  w requires that the s been signed by should be detach	ted t									ably 4 🗹 Unknown
	law rehas be	Completed						24a. Was autor perfo	osy pr		opsy findings available ompletion of cause of
	tal Rec		25 Was soon referred to madical	, <u></u>			(5)	1 <b>✓</b> Yes		✓ Ye	s 2 No
	Vital hysician this cert	Be Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient		Other Nursi	ng Home 5	Residence 6	Other	Scene
	n of ding Phy	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of		Injury at Work?	-	how injury occurre		
	sion ttendi death ctor: /	atio	1 X Natural 5 Pending 2 Accident Investiga			1[	Yes 2 No				
	Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could no	ot be 28e. Place of Injury -	At home, farm, stre	et, factory, offi	ce building, etc.	28f. Location ( or Town, S		or Rur	al Route Number, City
	Hospi 24 hou Funer ely fil		4 Homicide	ed (Specify)  clan: To the best of my kno	wledge, death occur	red at the time	e, date and place, and	d due to the cour	se(s) and manner	as state	d
	To the I- within 2. To the F- complete	Medical		er:On the basis of examinat and manner stated.							
_	- × - 5	ğΪ	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signer	1 (Mor	th Day Year)

Scene 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined 4 (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 22, 2008 30. Name and ad ss of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Month, Day, Year)

MAR 2 5

82. Registrar's Signature

09453

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 1115 AM 2008 185 har /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner House-Satyr Hill BALTIMORE arkville, MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. 1 1 M 2 □ F Days Months Hours 215-14-4293 Director 1-21-1921 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No BAITMORE Director Baltimore, Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3313 Delpha Ct. 21234 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltrio. City Sgt. Policeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Zavadil James Stefan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2815 Woodlyn Drive Fallston, Md. 21047 Helene Ebert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith 3-25-2008 Balto. City 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCUD /Medical Due to (or as a consequence of): Examiner LIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown alzehermers 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Renal insufficient 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) M53, Jed Liu. 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)
MAR 2 5 2008

Wen s

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



731291

4202

70 wson

3/21/08

DHMH 17 Rev 1/2001

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SLADKO 3 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🖵 F 213-36-8343 70 Director 8-9-1938 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b, County 28a-f show at a or 28a-f shot be notified a Director Md. Balto. Co. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ortant: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must b 21236 6 Cameron Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give<sup>X</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Harried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Mar 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 12th Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ladki 1 and 2 should be Health and Mental Elizabeth Beckman C. Robert Bullock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trans Frank Sladko 6 Cameron Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-22-2008 Moreland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Nonsmall cell careinoma of the disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Exami and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ned by the a 9□Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 2 No Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient P 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

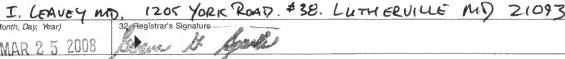
12

State Registrar 31. Date filed (Month, Day, Year) 2008

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who



completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

17041

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

months

10d Inside City Limits

1 ☐ Yes 2√2 No

8005

USA

Balto.

23d. Date of delivery

29d. Date signed (Month, Day, Year)

HARCH 19, 2008

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Baltimore

14. Race - American Indian.

Black, White, etc.

Md.

4:410 M

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 10, 2008 **Physician** 3:20 AM M Kenneth E. Schnepf Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 302 Breslin Road Joppa Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)

July 20, 1950 Maryland **Funeral** Days 1X M 2□ F 212-56-3946 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County **Phow** in than "naturel", or iteme 23a or 28a-f ehov The Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Joppa Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 USA 302 Breslin Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? be filed within 72 hours after de Ital Hygiene. Id other than "naturel", or Itemi Amed Follows,

1 ∑Yes 2 □ No

If Yes, Give

Year or Dates: 168-72 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Š 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) mailman postal system 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygh.
Important: If item 27 is marked.
any injury or other total. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rose Mary Hammerbacher Kenneth Edward Schnepf Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21085 302 Breslin Road Joppa, MD Donna Schnepf/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signatul of Funeral Services S. Wade Tirector State Anatomy Board 655 W. Baltimore Street me 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) & months Conces Physician /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attendingshysician and for use a the burial-transit The law requires that the death certifiate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 6/760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Brown Metastan Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perforr : After this certifice e funeral director, p or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) Medical Certification; To 27. Magner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. neral Director: A filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowled je, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and little of certifier 29c. License number March 17, 2008 024356 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) Suit 2200 7/03 Franklin & A Weinber Concer Institute at Fromple WATERFIELAMO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 25

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 4:20 PM **Physician** Jewel Dean Swinson 2008 MARCH 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RALTIMUTATION OF THE PROPERTY N/A AGNES HOSPITAL SAINT Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 238-50-7440 1933 74 Director North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 937 Vanderwood Road 21228 United States Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. ∏Yes 2 MNo Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No White Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important; If item 27 is marked other any Injury or other traumatic event, <u>it</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Preston Holmes Emma Stewart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1404 Stonehurst Drive., Annapolis, MD 21409 Sheila Rene Lagana - Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD Veterans Cemetery XBarial 2 □ Cremation 3 □ Removal from State 3-24-2008 Crownsville, MD 4 □ Dopation 5 □ Other (Specify) @ Crownsville
22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PMEUMONIA **Physician** MONTH /Medical Due to (or as a consequence of): Examiner STRUKE 1 MOMTH TEMORRHAGI ecquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit signed by the attending physician and c Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an PERTENSION page this certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Anatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 😢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

MATHEW

30. Name and address of person who completed

use of death (Item 23a) (Type, Print)

121800

MARCH

2008

		Please Type or Print in E						
		1- State of Marylan		artment of H rtificate of I			ene . No 2 A A B	09458
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Medi Exami		Albert Alvin Stinchcomb  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	March	17 200 4c. County of Dea	
		Baltimore Wishington Medical a		610n G	Burnie		Anne A	rundel
Funeral Director		5. Social Security Number 6. Sew 7. Age (In yrs. 1) M 2 F 65	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	Irs. 8. Date of Birth (Month, Day, Y) Mar. 30,	ear)	rthplace (State or Foreign Country) aryland
land ow st		Usual Residence of Decedent	y, Town or Lo	ocation		riar • Ju		10d. Inside City Limits
e Mary Ba-f sh rtifled a	Director	MD Anne Arundel		Glen Bu	mie			1 □Yes X□No
with th	Dire	10e. Street and Number		10f. Zip Code			. Citizen of What C	
r death	Funeral	11. Marital Status  12. Was Decedent Ever in U. Armed Forces?	.S. 13.\	Was Decedent of Hi	21060	(Specify Yes or No- lerto Rican, etc.)	United S	erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Del artment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 Never Married 2 Married 3 Widowed 4 Oriorced Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:	erto nicari, etc.)	Black, Wh	White
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within Jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired Brick Lay	) -		Magas	
be filed tral Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)		DLICK LAS	18. Mother's N	lame (First, Middle, Mai	,	lary
should nd Mer marke imatic	은	Ernest C. Stinchcomb, Sr.  19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a		Catherine B Rural Route Number, C		Zin Code)
and 2: ealth a n 27 is ier trau		Paul Stinchcomb - nephew	1			Glen Burni		
ages 1 Int of H t: If iter		1 Burial 2 Cremation 3 □ Removal from State	emetery, cren	sition (Name of matory or other place del	e)		c. Location - City o	
mit. P artme nortan v Injur.		4 Donation 5 Other (Specify)  21 Signature of Funeral Service Licensee	Cre	matory 2. Name and Addres	3=1	21-2008 O Ambrose Fu	denton, N	4D
Sames	1	Colline Clebert	2	719 Hammo	onds Fry	Rd. Lans	downe. Mi	21227
Physician		Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	3250	19490 00	g, such as card	lac or respiratory arrest	,	Approximate Interval Between Onset and Death
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ea yes	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ		Cocchicu	111	tarction	L	Hows
xecuted and	xamine	Sequentially llst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<u></u>				-	
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The law requires that the death certificate be the has been signed by the attending physicial bage 2 should be detached for use as the bur	sician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date of de	elivery Day Year
at the d by the	Physi	9 □ Unknown						
ne law requires that the de has been signed by the age 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resu	ilting in the un	iderlying cause give	n in Part I.			o the cause of death?
aw requisite pending section is been a should be should	Completed	Respondery lander	p 1	40 to ba	7/1 C	24a. Was an		utopsy findings available
	Com	Acidosis	1		<u> </u>	- autopsy performed 1 Yes 2	prior to death?	completion of cause of
/sician; Th	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No Hospital: 1 \( \text{No} \) Inpatient 2 \( \text{I} \)	ER/Outpatient	Othe	r·	eath (Check only one)		
ng Phy fter this	on: To	27. Manner of Death 1 A Natural 5 Pending (Month, Day Year)	28b. Time of	28c. Injury Work	4 🗆 Nursing	Home 5 Residence 28d. Describe how i		ecify)
Attendi death. ctor: A y the fu	icatio	Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At hou		M 1□Y	′es 2□No	19f Location /Ctrac	t and Number of	- Courte Manager
tal or A s after al Dire ed in b	Certification:	4 Homicide determined building, etc. (Specify	) )	set, factory, office		28f. Location (Stree City or Town, S	tand Number or H tate)	urai Houte Number,
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know and manner stated.	wledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and pla inion, death oc	ce, and due to the caus ccurred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
<b>To th</b> e within <b>To the</b> сощрк	Mec	29b. Signature and title of certifier.		29c. License	number	29d,	Date signed (Mon	th, Day, Year)
		Muy xem y		D00	327	44 M	arch 1	7 2008
1		30. Name and address of person who completed cause of death (Item  ARIA GAVIRIA MD 30	23a) (Type, F	Sprat /	Tax Gl	er Brrie	MO	21026
Sta Registr		31. Date filed (Month, Day, Year) MAR 2: 5 2008	ure					

Registrar DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

ST-AGNES

HOSPITAL, 900 S. CATON AVENUE

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MIALLIKA · ANGITIPALLI

31. Date filed (Month, Day, Year) 5

		State of Maryland / De 1 - State Amend #18 Per FH G877 3/26/		Reg. No.	3, Time of Death						
Physici		1. Decedent's Name (First, Middle, Last)  Raymond T. Slagle	Mon		10:05p M						
/Medio Examir		4a. Facility Name (If not institution, give street and number) 11115 Worchester Drive	4b. City, Town, or Location of Death New Market		4c. County of Death Frederick						
Funeral Director		5. Social Security Number  260-17-4575  6. Sex 1 □ XM 2 □ F  7. Age (In yrs. last birthd. 42 Yrs. 42	ay) If Under 1 Year If Under 24 Hrs. 8. Date (Mor Months Days Hours Min. 01)	of Birth 9. Birth 1th, Day, Year) 718/1966	thplace (State or Foreign ountry) GA						
laryland show	o.	Usual Residence of Decedent	Location New Market		10d. Inside City Limits 1 ☐ Yes 2 No						
with the Maa or 28a-f	I Director	10e. Street and Number 11115 Worchester Drive	10f. Zip Code 21774	10g. Citizen of What C	ountry?						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Yes 2 □ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e  1 □ Yes 2 □ No Specify:								
within 72 hor ene. than "natur the Medical E	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired) Soldier	U.S. Arr	-						
l be filed wintal Hygier ed other the	Be	12 5+ 17. Father's Name (First, Middle, Last) Thomas Slagle	18. Mother's Name (First,		2						
nd 2 should be file th and Mental Hy 27 is marked oth traumatic event	우	19a. Informant's Name/Relationship (Type. Print)  Regla Slagle / Wife 1111	ailing Address (Street and Number or Flural Floute 15 Worchester Drive, Ne	Number, City or Town, State, w Market, MD	Zip Code) 21774						
mit. Pages 1 and 2 partment of Health portant: If Item 27 i y injury or other tra		20a. Method of Disposition 20b. Place of Disposition	sposition (Name of crematory or other place) emorial Gardens 3 27 08	20c. Location - City o							
permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Charles L. Stevens Fu 1501 Fast Fort Avenue	neral Home In	C. MD 21230						
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Beautiful Cause (Final disease or condition  a. MTASTAFTC Dualet NA CARCER									
ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			2006						
The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	3d. Date of delivery Month Day Year						
uires that in signed by	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23	e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	to the cause of death? Probably 4 □Unknov						
The law requires to the has been signed age 2 should be to	Completed			a. Was an autopsy performed? death	autopsy findings availab o completion of cause of ? es 2 \sum No						
ling Physiclan: After this certifica	Certification: To Be C	25. Was case referred to medical examiner?  1	ne of	k only one)  Aesidence 6 Other (Specifie how injury occurred cation (Street and Number or y or Town, State)							
To the Hospital or Attent within 24 hours affer death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, can be sufficient to the best of	leath occurred at the time, date and place, and du or investigation, in my opinion, death occurred at th	e to the cause(s) and manner ne time, date and place, <b>an</b> d d	as stated. lue to the cause(s)						
To the within To the Comple	Mec	29b. Signature and title of certifier	29c. License number  MASY (AND ) 602	29d. Date signed (Mo	nnth, Day, Year)						
K		30. Name and address of person who completed cause of death (Item 23a) (T)	PRINTER SOUT STATES	orbit AVE B	FTARDD M						
Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature									
OHMH 17 Rev 1/2	2001		ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 0946 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Edward Augustus Stewart 50 7M MARCH 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE SINAL HOSPITAL OF BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours 212.32.6987 11/12/1934 Director Usual Residence of Decedent 10a. State 10b. Counfy 10c. City, Town or Location ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medi al Examiner must be notified at 10d. Inside City Limits MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3613 Manchester Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White, etc. 1 X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bon Secours College (1-4or 5+) Elementary/Secondary (0-12) Security Guard Hopital 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred MCCON 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2
Department of Heelth a
Important: If Item 27 Is any Injury or any Gloria Ashe Stewart ( 3613 Manchester Avenue Baltimore MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 03/22/08 | Baltmore, MD 21. Signature of Funeral Service Licenses 22. Name and Address Facility Vaughn C. Greene Funcial Services 8728 Liberty Road Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic Anoxic Encephalopathy
Due to (or as a consequence of): 2de /Medical Examiner Rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) and Box 68760, attending physiclan Myocardial Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 progressive breast cancer Hypertension 1 Tes 2 **X** No 3 Probably 4 Unknown Chronic Kidney disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy 2 No 1□ Yes 2 XN0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 2 Accident 5 ☐ Pending investigation Within 24 hours after .....
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number RES-000 2012008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Bharat

MAR 25

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

The state of the s	To the Hospital or Attending Physician: The law requires that the deswithin 24 hours after death	To the Funeral Director: After this certificate has been signed by the at	completely filled in by the funeral director, page 2 should be detached for
	To the Hospital or Attending F	To the Funeral Director: After	completely filled in by the funers
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			For State Registrar		Maryland / Dep		Health and I	Mental Hy	giene 2 0	108 09462
	Teles		Registrar  1. Decedent's Name (First, Midd	la Last)	O E	er unicate or	Deain		Reg. No.	0.5
	Physici /Medi		Robert	L L	Street	ter		2. Date of De Month March	Day	Year 3. Time of Death 4:10 PM M
	Examir		4a. Facility Name (If not institution	n, give street and nur	nber)	4b. City, Town,	or Location of Death	1	4c. County	of Death
		-8	Brighton Garde	ens		Bethes	da		Montgo	mery
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthda)	/) If Under 1 Year Months Days		8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
١.	Director		182-14-3078	<b>X</b> M 2□ F	85 Yrs.	Working Baye	Tiodio IVIII.	June 17		Pennsylvania
	pu ,		Usual Residence of Decedent  10a, State 10b, County		40- Ott. T					
	72 hours after death with the Maryland natural", or items 23a or 28a-f show itsel Examiner must be notifled at	_	10a. State 10b. County	/	10c. City, Town or I	ocation				10d. Inside City Limits
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	or 24	Sire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	23a ust b	la	5550 Tuckerman	Lane		20852			U.S.A.	
	ems	Ine	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U.S. 13	. Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No	- 14. Rac	e - American Indian, ck, White, etc.
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2	er th	Ö		4	Me	chanical	Engineer		Wagner	Group
pu	al Hy	Be (	17. Father's Name (First, Middle	. Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surnan	ne)
/a	uld b Ment Irkec	힏	Robert L. Str	eeter			Louise	Rapalje	Street	er
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med	ı.	19a. Informant's Name/Relations	ship (Type. Print)	19b. Mai	ling Address (Stree	t and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip Code)
	and 2 alth alth 27 i		Robin Streete	r (Daught	er)   7901	Cypress	Place, Ch	nevy Cha	se, MD	20815
Baltimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla	ace)	Date	20c. Location -	City or Town, State
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alti	ortal		21. Signature of Funeral Service						ALCAMIN	urra, va
Ä	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		1 de la constante de la consta	12/1/		Kuhn Fune 739 Penn	ess of Facility eral Home, Ave., Wes	, Inc.	n a D A 1	0611
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			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on e	ach line.	11000	A Low	lure		Approximate Interval Between Onset and Death
19	Physician /Medical		disease or condition resulting in death)	a. (	ongest ine	7)000	3	70 00		
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Вох	ath ce tend or use	an/	23b. Was decedent pregnant in the past 12 months?		come pf pregnancy rth 2 ☐ Fetal death 3	□Ectopic pregnane	cy			te of delivery
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	and and and and and and and and and and		Part II. Other significant conditi	ons contributing to de	ath but not resulting in the		ven in Part I.	23e. Did t	obacco use cont	ribute to the cause of death?
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or Vital Records,	s bee	Completed by	γ ,					24a. Was		Were autopsy findings available
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tal	iffical or, p		25. Was case referred to medica	ıl			06 Flans of Dan	1□ Yes		1 ☐ Yes 2 ☐ No
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o	Phys r this ral dir	<u>유</u>	27. Manner of Death	28a. Date o	·	III OLI DOA	4 A Nursing H		dence 6 Oth	
Division	Attending F r death. ector: After by the funera	Certification:	1 X Natural 5 ☐ Pendi	ng (Mont	h, Day Year) Injury	Wo	ork? ∃Yes 2∐No	Zou. Describe	low injury occur	eu
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>	or A fiter ( Direct in by	ŧ	4 ☐ Homicide determ		ng, etc. (Specify)	ireet, lactory, office	1	City or Tol	street and Numb vn, State)	er or Rural Route Number,
	oltai urs a erail			31 11 7 11						
	To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1. Certifii (Check only one) 2 Medical	Examiner: On the ba	best of my knowledge, dea sis of examination and/or	im occurred at the t investigation, in my	time, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
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	<b>5</b> ₹ <b>6</b> ©		29b. Signature and title of certific	1 XIAC	Se -	29c. Licen	67 69 1			d (Month, Day, Year)
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-	17		30. Name and address of person	1						
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State of Maryland / Department of Health and Mental Hygiene  Certificate of Depart  Physician    Department of Health and Mental Hygiene   State of Maryland / Department of Health and Mental Hygiene   State of Maryland   State of Department of Health and Mental Hygiene   State of Maryland   State of Department of Health and Mental Hygiene   State of Maryland   State of Department of Health and Mental Hygiene				i iedse i	State of Ma											
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Physician Medical Examiner    Sequential Continues   Physician Medical Examiner   Physician Medical Exa		- N		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused ne cause on each lin	the death. e.	. Do not en	ter the mode	of dying	, such as	cardiac or	respiratory	arrest,		Interva	Between
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Charat Mingrand General Hospital  State  31. Date filed (Month, Day, Year)  32. pogistrar's Signature		o the	Me		and mailler sta			29c.	License	number			29d. Da	te signed /Mo	onth, Dav. Ye	ar)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** nexa Cot 19,7508 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CONTER 2 AND AllSTENN Monttleves If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Aug. 31,1965 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F Michigan 42 Director 219-74-7737 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No Director MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 'natural", or items 23a 12006 Tarragon Road, Unit D 21136 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Writing Writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be injury or other traumatic Thomas R. Scott Joy Moline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Carolstowne Road, Reisterstown, MD 21136 Lauri A. Shaw Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/20/08 Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road line Eline Funeral Home Reisterstown, MD 21136 anst 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** NEUMONYA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ENTEROCOCOUS BACTEREMINE use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, CLOS TR'Dium Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE RESPIRATORY FAILURE: CHARLOGE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed DENTIL VALVE ENDECKADITE 24b. Were autopsy findings available prior to completion of cause of death? autopsy Di+B=Tis Millitus PANOREATICE THANSPLAN 1 □Yes i or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of pertifier

ORIANDO

31. Date filed (Month, Day, Year)

MAR 25

uch)

29c. License number

19502

29d. Date signed (Month, Day, Year)

RANDAUSTOWN MANGLAND

and manner stated.

CONANAN

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		-	For State Registrar	State of Maryland		artment of H rtificate of l			giene Reg. No.	008	094	65
	Physicia	an	1. Decedent's Name (First, Middle, Last) ENID		SANI	DLER		2. Date of Dea Month MARCH	Day	2008	3. Time of E	Death A <sup>M</sup>
	/Medic Examin	400	4a. Facility Name (If not institution, give str HOSPICE OF BALTIM		СТР	4b. City, Town, or TOWSON	Location of Death			ounty of Death		
٥	Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 10/31/1	h		place (State or ntry) FL	Foreign
	yland Iow at		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	eation					0d. Inside City	
	ne Mar 8a-f sh otified	Director	MD BALTI	MORE		TOWSON			10- 011-		1  Yes	2 🔼 No
	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 6521 N. CHARLES S				1212		l	n of What Coul		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2ズ No		ecify Yes or No Rican, etc.)		Race - Americ Black, White, Specify: WH	etc.	
21215-0036	n 72 ho " <b>natu</b> i edicai	Completed by	15. Decedent's Educa (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work d)	ing	16b. Kind	l of Business/In	dustry	
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and	d be file ental Hy ced oth c event	Be	17. Father's Name ( <i>First, Middle, Last</i> )  HARRY		SAI	NDLER	18. Mother's Nam	•	Maiden S		LLERBAC	CH
Baltimore, Maryland	and 2 should lealth and Men m 27 Is marke her traumatic	2	19a. Informant's Name/Relationship (Type LOIS LOWENTHAL / S.			ng Address (Street HAMILL CO					21210	)
imore,	Pages 1 ament of He ant: If item iury or othe		20a. Method of Disposition  1	moval from State	BetSHA	osition (Name of majory or other place PARK	03/23	Date 8/2008	REIS	ation - City or T	N, MD	
Balt	permit. Departm Importar any inju		21. Si haure of Runeral S, rvi e / censes	N		2. Name and Addre 8900 REIS	TERSTOWN	L LEVIN	PIKES			208
	Physician	ar i	23a. Part1. Enter the disease, or complir shock, or heart failure. List only of Immediate Cause (Final disease or condition	ations that caused the death cause on each line.		ter the mode of dyir		or respiratory a	rrest,		Approximate Interval Betwoonset and D	veen
120	/Medical Examiner		resulting in death)	ue to (or as a consequ	uence of):	Core					1	
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80,73	ificate be executed y physician and ss the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
68760,	# D K	Medical	d.									
P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	i death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23	d. Date of deliving Month	,	'ear
	quires that I in signed by uld be deta	þ	Part II. Other significant conditions cont	ributing to death but not rest	ulting in the u	ınderlying cause giv	ren in Part I.	23e. Did t	_	e contribute to	the cause of d bably 4 □U	
Division or Vital Records,	2 % 2	Completed								death?	opsy findings a completion of ca	available ause of
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth	26. Place of Dea	th <i>(Check only c</i> ome 5 ☐ Resi		Mother (Spec	in las	nû.
n or	ng Phy (fter this	on: To	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injui	ry at rk?	28d. Describe		_	···	
<b>Divisio</b>	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif			Yes 2 □ No	28f. Location ( City or To		Number or Ru	ral Route Num	ber,
_	To the Hospital of within 24 hours at To the Funeral Completely filled it	edical Ce		cian: To the best of my kno er: On the basis of examina and manner stated.								5)
)	To th within To th compl	Me	29b. Signature and title of certifier	m		29c. Licens	58303		29d. Date	signed (Month	, Day, Year)	
	10		30. Name and address of person who cor	npleted cause of death (Iten	23a) (Type	Print) 1. Charle	y 5+	TUVSE	NM	0 21	204	
-40	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 5 2008	32 Registrar's Signa	ture	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 8877 3-25-08 yt State of Maryland Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 655 RM 200 198 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death **Examiner** 10009 o/auss TO 41 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex **Funeral** 12<sup>(M</sup>27# /1921" 069-16-6578 1 □ M 2 💢 F 86 0H Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at MD HOWARD 1 ☐ Yes 2 X No COLUMBIA Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 CEDAR LANE 21044 death v Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: WHITE þ Specify: 3 X Widowed 4 ☐ Divorced Completed the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than any injury or other traumatic event, the Monee. COMPUTER SPECIALIST COMPUTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL WEISS ANNA GOLDSTEIN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Rule N GOFF City Co V dwy, State, Zip Code) MELVIN SCHWARTZ / SON 10052 WATERFORD DRIVE, COLUMBIA, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MT. LEBANON 03/24/2008 ADELPHI, MD 4 □Denation 5 Other (Specify) 21. Sid 22. Name and Address of Facility of Funeral Service SOL LEVINSON & BROS.. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. physician at s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 9 1 ☐ Yes 2 No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Harderitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

OJ

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Z/ON PAD

31. Date filed (Month, Day, Year)

MAR 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 23 Day 2008<sup>ear</sup> **Physician** 12:55 R Carol Smuda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Med. Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 27, 1946 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Months Days Hours Min. 217-46-2856 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No Md. Anne Arundel Pasadena 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21122 21122 8235 Ventnor Rd, Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Programmer US Dept. of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Wilson William Irma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 675 Apple Rd. Quakertown, Pa. 18951 Deborah S. Williams Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 Other (Specify 3/26/08 Glen Burnie, Md. Glen Haven Cemetery 22. Name and Address of Facility Stallings Funeral Home PA 21. Signature of Funeral Service License 3111 Mountain Rd, Pasadena, Md. 21122 23a. Part1 - Inter the disease, or complications that shock, or heart failure. List only on a cause on thal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician; The law requires that the death certificate be executed the burial-trans Liebus Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy for Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Division or Vital Records, P.O. Box 68760,

Hospital or Attending within 24 hours after death To the Funeral Director;

completely filled in by the funeral

State Registrar

Medical

· Ambalavanar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

MAR 2 5 2008



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

alen Bornie MD21061

				For State Registrar	State of Marylan	_	artment of He rtificate of D			giene , Reg. No. <sup>(</sup>	2008	09468
	Н	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month 03-20-		Year	3. Time of Death
		/Medic	al	Helen L. Thomas  4a. Facility Name (If not institution, give s	atract and number)		4b. City, Town, or L	ocation of Death	03-20-		County of Death	0433 A **
		Examin	er	Stella Maris	sireet and number)		Timoniur				ltimore	
		Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign
	П	Director		219-16-8977	<sup>1M 2</sup> ₹F 82	Yrs.	Months Days	Hours Min.	05-10-	1925	Mary	olace (State or Foreign ntry) Land
		land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
		death with the Maryland rms 23a or 28a-f show Limust be notified at	ţoţ	Pennsyvania York		allas	town					1 □Yes ※ No
		r 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cour	ntry?
		th with	alD	490 North Walnut	St		17313			U.S.	Α.	
•		ems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 1·	4. Race - Americ Black, White,	
a. II	21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Piscical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2 ሺ No If Yes, Give Year or Dates:		1 □Yes 2 <b>X</b> No	Specify:			Specify: Whi	
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	2	led w dygie her ti		17. Father's Name (First, Middle, Last)		Secre		18. Mother's Name				5 UIIIOII
2008	and	d be fault of the color of the	Be (	John Gracki				Mary Mar		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	
. 2	Z	should mark matic	ဍ	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Maili	ng Address (Street a	nd Number or Rur	al Route Numb	er, City or	Town, State, Zip	Code)
20,	$\mathbf{z}$	nd 2 s allth ar 27 is r trau			(Daughter)	1	N. Walnut					
H	Ē,	is 1 al		20a. Method of Disposition	20b. F		osition (Name of matory or other place		Date		ation - City or To	own, State
MARCH	altimore, Maryland	Page nent d int; if		1 A Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Forest Co		5-2008	Owin	gs Mill	s, MD
Σ	Balti	permit. Departr Importa any inju		21. Signature of Funeral Service License	ha Oc	2	2. Name and Address					e
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		Physician		shock, or heart failure. List only or Immediate Cause (Final			COYPUM					Interval Between Onset and Death
		/Medical		disease or condition resulting in death)	. CEREBROVASO  Due to (or as a conseq		ACCIDENT					
350		Examiner		Convention link condition o								
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		and trans	Examiner	that initiated events resulting in death) Last C.  Due to (or as a consequence of):								
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	68	tificat ig phy as the	ledical				202.25				252	
	Box	eath certifi attending   for use as	N/ug	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnancy			2	3d. Date of deliv	•
	-	e death o	Physician/M	in the past 12 months? 1 □ Yes 2 <b>X</b> No	4 ☐ Pregnant at time of o		Other (specify)				Month	Day Year
THOMAS	<u>P</u> .	ires that the de signed by the a I be detached f		9 ☐ Unknown  Part II. Other significant conditions cor	atributing to death but not res	ulting in the 1	ınderlying cause give	n in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
E	Division of Vital Records,	requires to een signe nould be c	d by	Tartin Guidi Gigini Guid					10	Yes 2	]No 3☐ Pro	bably 4 📉 Unknown
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	/ita	ysician: The iis certificate h director, page	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only	one)		
	ž	<b>ys</b> .⊵ .∃	၉	1 ☐ Yes 2 🛣 No	fospital: 1 ☐ Inpatient 2 ☐	<del></del>		4 LI Nursing H				fy) HOSPICE
	Ju C	ling P	io io	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Work		28d. Describe	how injury	occurred	
	isi	Attending r death. sctor: Afte	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	nme farm st		′es 2 □ No	28f Location	Street and	Number or Bur	al Route Number,
	<u>≥</u>	lor A after Direc d in b)	Certification:	4 Homicide determined	building, etc. (Specif	y) (101111, 00	root, ractory, office		City or To	wn, State)	ritumber of rium	ay Fronte Warnson,
		To the Hospital or Attending Ph within Z4 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the time	ne, date and place pinion, death occur	, and due to the red at the time	e cause(s) , date and	and manner as place, and due t	stated. o the cause(s)
		To the within 2 To the comple	Me	29b, Signature and title of certifier			29c. License	number			e signed (Month,	
		, T)		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	(					
		10		DR. TARIO MAHMOOI	2300 DULANI	EY VAL	LEY RD. I	TIMONIUM,	MD 210	093		
		Sta Registr		31. Date filed (Month, Day, Year) MAR 2 5 2008	32. Registrar's Signa	ture						
					<u> </u>	ÓM.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WIHOW Marcy, 2-3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City Ellicott City Health & Rehab Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 □ F 87 199-12-5847 Yrs. Sept.24, 1920 Pennsylvania **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 282.4 any injury or other traumatic event, Ite Market 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Maryland Howard Director Ellicott City 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 3020 N. Ridge Road W313 21043 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1940–46 1 ☐ Yes 2 ➡ No Specify: Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security College (1-4or 5+) Elementary/Secondary (0-12) Claims Examiner Administration 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be James Vincent Traglia Lucia Luciani 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Traglia 31574 Winterberry Parkway; Selbyville, DE Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 13/26/2008 4 □ Donation 5 □ Other (Specify) Greek Orthodox Cem. |Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Lensee No1290 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (av)10myorath **Physician** /Medical Due to (or as a consequence of): Examiner StagE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed LOFUNGUL and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> DISPASA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signal, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1. Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Lirector n by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely within 2 To the I the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number withen mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH GEH, MD 21201. 2, SUITE 62. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 5 2008

			Pleas	se Type or Prir							•	
			For State	State of Ma	aryland			Health and I	Mental Hy	/giene		
		-	Registrar	t 4)		Cel	rtificate o	T Death	2. Date of D	Reg. No	2008	1991.70
	Physicia	an	Decedent's Name (First, Middle, George	Last)	To 1	cesuye			Month March		y 2008 Year	12:35 PM
	/Medic		4a. Facility Name (If not institution,	give street and number)	lai	cesuye		n, or Location of Death			County of Deat	
	Examin	ier	Angels Garden	-			7	Spring			ontgome	
So veny	Funeral			6. Sex 7. Ag		a <i>st birthday)</i>	If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Bi	irth	9. Birt	hplace (State or Foreign
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pur	>		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ecation					10d. Inside City Limits
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deat	ems 2	ner	11. Marital Status	12. Was Decedent Armed Forces? 1 \( \text{Yes} \) 2 \( \text{X} \)!	Ever in U.S	S. 13. 1	Was Decedent of	of Hispanic Origin? (S Suban, Mexican, Puerl	pecify Yes or N	0-	14. Race - Ame Black, White	
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withi	than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Baby	Chick	Segregator	•	Pou	1try	
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2 sho	and Is ma		19a, Informant's Name/Relationsh	ip (Type. Print)				eet and Number or Ru				Zip Code)
and	ealth m 27 her tr		David Takesuye	(Son)	Jack Di		Kirksid	e Dr., Che	evy Chas	т		Town Chata
ges 1	Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation		C	emetery, c <del>re</del> i	matory or other <sub>l</sub>	place)			ocation - City or	
it. Pe	rtmer rtant njury		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Meti			matory 3/2		ATE	xandria	, VA
per l	Depa Impo any ir once		21. Signature of Fulleral Service L			Ğ	oodwin	dress of Facility Funeral Ho tnut St.,	me Manches	tar	NH 031	04
			23a. Part1. Enter the disease, or	complications that caused	the death						WII ODI	Approximate
Ph	ysician		shock, or heart failure. List of Immediate Cause (Final	only one cause on each li	ne.		Achie	<b>A</b>				Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as	a consequ	ience of):	11 107	Disces				20 years
Ex	aminer		Sequentially list conditions	b								
D V	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):						
xecut	ian and urial-transit	xam	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):						
ficate be ex	n. Affer this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transfer.				,	,						
ifficate	g physas the	edic		0.								
ath cert	anding use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			⊒Ectopic pregna	nov			23d. Date of del	ivery
deat	ne atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 🗷 No	4□Pregnant at			Other (specify				Month	Day Year
at the	d by the	Phy	9 Unknown			. It is a last of	and adviser and an	given in Deut I	220 Did	toboooo	uon contribute to	the cause of death?
ires th	signe I be d	by	Part II. Other significant condition		ut not resu	nung in the u	indenying cause	given in Fait i.			<u>.</u>	robably 4 □Unknown
law requires t	shoute	Completed	7.700	115						•		
ne law	ge 2 s	mpl							24a. Wa aut per	opsv	prior to	utopsy findings available completion of cause of
ם ב	ficate or, pa		25. Was case referred to medical					00 Plans of Pa			1 □ Yes	
VII /sicia	s certi	o Be	examiner?  1 \( \text{Yes} \) 2 \( \text{X} \) No	Hospital:	ent 2□	ER/Outpatier	nt 3 DOA	26. Place of Dea			6 Nother (Spe	Assisted  city)Living
9 F	er this eral c	n: To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time o		njury at Nork?	28d. Describe			CAN LIVING
ng in	ath.	atio	1 Natural 5 Pending 2 Accident investig	ation	y rear)	Hijury		Yes 2 No				
r Atte	irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At ho c. (Specify	me, farm, str	reet, factory, offi	ce		(Street ar		ural Route Number,
Jalo	urs aff eral D illed ir			Physician Table has	-6	uladaa daat	de	a Nima alata and Inc.				
DIVISION OF VITAIN THE COURS, F.O. BOX 00/00, for the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical		g Physician: To the best Examiner: On the basis of and manner st	f examinat							
To the	vithin Fo the	Me	29b. Signature and title of certifier				29c. Lic	ense number		29d. Da	ate signed (Mont	th, Day, Year)
, [			1 Brut	Cl. A	۸n		0 9	0 6 6 12	9	Mar	ch 21,	2008
			30. Name and address of person v	who completed cause of c	leath (Item		Print)					20815
	,		Brest Col	e MO	and C:	553	0 Wisco	nsin Ave.	Suite #	730	Chevy C	hase, MD
	Sta Registr		31. Date filed (Morth Apr. Year)	2008 32 Registr	ar s Sigria	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:03 PM **Physician** MARCH Claude Taylor 15 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORG GOOD SAMAKITAN | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | N 9. Birthplace (State or Foreign Country) unk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 71 Director 213-34-4238 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location sa or 28a-f show t be notified at 10a. State 10b. County 1√Yes 2 No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 6000 Bellona Avenue USA r items 23a o by Funeral unk 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No ur 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Megunes. Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Good Samaritan Hospital 6501 Loch Raven Blvd Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (\$pecify) in state konald S, Wade, Drector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature -- F ma 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Chose (Final HYPOXAEMIC RESPIRATING FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PN EUMONIA HSPIRATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine HENZTEMICIS physician and s the buriat-trans Due to (or as a consequence of): SBUEKE Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Be 2 Certification:

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

within 72 hours after death

 $\int \mathcal{A} \ \sqrt{\ \partial \epsilon} \ / \ \mathcal{O} / \mathcal{A} \mathcal{A}$ Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: /

- ENCE	PHALOI	DATHY			1 ☐ Yes 2 ☐	No 3 Probably 4 Unknown
	RON MY	ALZEKY	DISONS	<u> </u>	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred	d to medical			26. Place of D	eath (Check only one)	
examiner? 1 ☑ Yes 2 ☐ No	。	Hospital: 1 ☐ Inpatient 2 🖸	€R/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	☐Other (Specify)
27. Manner of Death 1 □ Natural 2 □ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3□ Suicide 4□ Homicide	6 Could not be determined	28e. Place of injury · At he building, etc. (Specif	ome, farm, street, fact y)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
		ysician: To the best of my kno niner: On the basis of examina and manner stated.				and manner as stated. place, and due to the cause(s)

29b. Signature and title of certifi

ATTONDING PHYSICIAN 29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per-

2008

DOD 62 239. DE MAN NAING OO, MI

2008 MARCH

600D 31. Date filed (Month, Day, Year) State MAR 25 Registrar

Medical

17 m 32 Registrar's Signature

HOSPITAL

		1	For State of Ma	arylaffd / Depa <i>Cer</i>	inment of He tificate of D			giene Reg. No.		
			Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year 3. Time of Death			
	Physicia /Medic	al _	Maurice Russell Troxe	211				20, 2008 4c. County of Dea		
	Examin	er	4a. Facility Name (If not institution, give street and number)  Future Care Cherrywood	a	4b. City, Town, or L	erstown		Baltir		
	Funeral Director		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday) 84 Yrs.		If I Indox 24 Hrs	8. Date of Bird (Month, Da Sep • 2	h 9. Bi	rthplace (State or Foreign ountry) aryland	
	w .	F	Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits	
	Maryla -f sho iied at	tor	MD Baltimore	0	wings Mi	.11s			1 □Yes XXNo	
	th the or 28a e notit	Sirec	10e. Street and Number		10f. Zip Code			10g. Citizen of What C		
	s 23a nust b	Funeral Director	105 Allgate Rd.	Ever in U.S. 13 \	211		ecify Yes or No	U . S .		
0000	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 23a-f show or other traumatic event, the Medical Examiner must be notified at	by Fun	11. Marital Status  1 □ Never Married XXMarried  3 □ Widowed 4 □ Divorced  12. Was Decedent to Armed Forces?  X X Yes 2 □ N If Yes, Give Year or Dates:	vo 1943_	Was Decedent of His If Yes, specify Cuban 1□ Yes  XXNo	, Mexican, Puerto Specify:	Rićan, etc.)	Black, Wh	tte, etc. White	
5	72 hou natura lical E		15. Decedent's Education (Specify only highest grade completed)	16a Decer	dent's Usual Occupat kind of work done du DO NOT use retired)	ion Iring most of work	ing	16b. Kind of Business	•	
Z	vithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5	i+) life. L	Painter		_	Painti <del>Painte</del>		
70	filed within Hygiene. other than " ent, the Me	ပ္ပ	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle	, Maiden Surname)		
yland	should be nd Mental marked o	To Be	Russell Troxell				Spra			
Mary	2 should and Men Is marke		19a. Informant's Name/Relationship (Type. Print)	1				er, City or Town, State, Mills, M		
ď	1 and Health em 27		Doris M. Troxell / Wif		osition (Name of matory or other place		Date	20c. Location - City of		
Ē	Pages nent of int: If its iry or o		1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro C	rematory		5/08	Baltim	ore, MD	
Baitimor	permit. Page Department. Important: If any injury o		21. Signature of unital ervice Licer to	22	2. Name and Address				hapel P.A. 11s,MD21117	
٢			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lit	I the death. Do not ent	ter the mode of dying	, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Physician		regulting in death)	tocellular	carcinary	14			7 moj	
	/Medical Examiner		Due to ras	a consequence of):						
9		Jer		a consequence all):						
	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C							
60,	icate be executed physician and s the burial-transit	al Ex	Due to (or as	a consequence of):						
68760	ficate g physics the	edical	d							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(sp</i> ec <i>ify)</i>			23d. Date of d Month	lelivery Day Year	
1	uires that the de signed by the a Id be detached for	by Ph	Part II. Other significant conditions contributing to death b	out not resulting in the u	inderlying cause give	n in Part I.			to the cause of death?  Probably 4 □Unknown	
ord	w requir been si should		riepairii				24a. Was	7	autopsy findings available	
Records,	The law cate has b page 2 s	Completed					auto	opsy prior to ormed? death	o completion of cause of	
Vital	iician: Th certificate ector, paç	Be Co	25. Was case referred to medical			26. Place of Dear			85 20140	
> _	hysici his ce Il direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpati			41X Nursing Fi		idence 6 Other (S	pecify)	
S L	ing P. After t	jon:	27. Manner of Ceath  1 Natural  5 Pending investigation  28a. Date of Inju (Month, Da		Work	ratr ? /es 2∐No	28d. Describe	how injury occurred		
Division or	or Attendath after death Director; in by the	Certification:	3 Suicide 6 Could not be 28e. Place of in	jury - At home, farm, st tc. <i>(Specify)</i>			28f. Location City or To	(Street and Number or own, State)	Rural Route Number,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or it	th occurred at the tim nvestigation, in my op	ne, date and place pinion, death occu	, and due to the	e cause(s) and manner e, date and place, and o	as stated. lue to the cause(s)	
	To the within To the comple	Me	20h Signature and title of celtifier		29c. License			29d. Date signed (Mo		
			De Supe Wille N	(D)		0680		March 2		
	TI,		30. Name and address of person who completed cause of ELYSE L. MICITERO	death (Item 23a) (Type,	Mainstre	et Reist	tentow	n, MD 21	136	
	St Regist	ate rar	31. Date filed (Month, Day, Year) 2008 Regist	trar's Signature	artie)					

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** TYBER FRANCIS 22 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner RALTIMORE JOHNS HOPKINS BAYVIEW MEDICALCENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Aug 12, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 76 218-26-2025 MXX Maryland Director Usual Residence of Decedent the Manyland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 Bethlehem Avenue 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★JYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Beth Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis J. Tyber, Julia Elizabeth Jancziewski ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecilia B. Tyber (wife) 1203 Bethlehem Avenue Baltimore, Md. crematory or other place) Hill Mem Gar 3-25-2008 Middle River, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Holly 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Tolut for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1201 Dundalk Ave. Baltimore, Md. Immediate Cause (Final ISCHEMIC STROKE MASSIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 1/2001

State

10+1

mD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENEEN M. GIFFORD, MD

31. Date filed (Month, Day, Year) MAR 2 5 2008

RES-000

4940 EASTERN AVE BALTIMORE UD 21224

MARCH 22 2008

# death with the Maryland show and 2 should be filed within 72 hours after 3aftimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traument.

for use as the burial-trar Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria After this certificate has funeral director, page 2 or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 06 2008 /Medical 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year)
March 3, 2008 9. Birthplace (State or Foreign Country) **Funeral** Hours Min. 2 □ F none Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director MD Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 5505 Justina Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ogechukwu Ugbam Victoria A. Ajegwu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Hospital 22 S. Green Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state 21. Signature of Euneral Serv S. Wale, Director State Anatomy Board 655 W. Baltimore Street 23a. P.11. Enter the dis. se, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipk, or heart failure. List only one cause on each line. Approximate Interval Betw d Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attenwithin 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16770 Name and address of posson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month) Day, Street as B 110, balti more MS 2120, 29 S Greene Year) State 2008 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22 Day 2008 Year Physician 5:50 Рм Beulah May Vestal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 35KF 220-20-6802 Director 80 05/17/1927 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at Director 1 ☐ Yes % No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ any injury or other traumatic. 21221 U.S.A. Funeral 2027 Middleborough Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify ò Specify: White ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Billing Clerk Medical Records 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Phillips William Godwin Ouillin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 9th Street SW, Washington D.C. 20024 Linda Riggin (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/24/2008 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Furtiral Sources Icensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm. nate Cause (Final dise r condition **Physician** Sycast concer was /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Was file ဥ 2 ER/Outpatient 3 DOA this ( 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: 

Medical

31. Date filed (Month, Day, Year) Registrar MAR 25

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAWES W

2008

N. Charles It muser up 2/204 6707 32 Registrar's Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 WIRTH 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RALTIMORG ALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 ☑ M 2 ☐ F 53 216-62-3915 5-26-1954 Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ¥ Yes 2 □ No Md. Baltimore, Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Echodale Avenue Apt.D 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: White 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wirth Alice Streett 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Riedal Sister 12205 Manor Rd. Glen Arm, Md. 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 3-27-2008 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sdays Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ➡ Nō 24a. Was an autopsy performed 1 es 2 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

The law requires that the death certificate be exect Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

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Examiner

Completed by Physician/Medical

Be

Medical Certification: To

29a. Certifier

(Check only one)

NABIL

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

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Maryland 21215-0036

Baltimore,

or Attending Physician:

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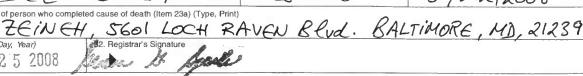
State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

### 08-02043 Charles T. Wess

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Directors  Chart Les Thomas  Thomas  Chart Les Thomas  Thomas	ıldı	nes I. vvess		State of Maryland / Department of Health and Mental Hyster State  Certificate of Death Registrar	yglerie Reg. N	to. 200	0 001.7			
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29b. Signature and title of certifier  O.C.M.E.  March 14, 2008  30. Name and address of person who completed cause of death/(flem 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  22c. Registrar's Signature		Visic or Atter frer dea Director in by th	ificat	28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City			
29b. Signature and title of certifier  O.C.M.E.  March 14, 2008  30. Name and address of person who completed cause of death/(flem 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  22c. Registrar's Signature		Diversal control of filled	Cert	4 Homicide determined (Specify)	<u> </u>					
29b. Signature and title of certifier  O.C.M.E.  March 14, 2008  30. Name and address of person who completed cause of death/(flem 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  22c. Registrar's Signature		the Hothin 24 in the Fu	dical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	id due to the cause(s at the time, date an	s) and manner as s d place, and due to	stated. the cause(s)			
30. Name and address of person who completed cause of deathy (tiem 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)		To To	Me	29b. Signature and title of certifier 29c. License number	nature and title of certifier 29c. License number 29d. Date signe					
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  22. Registrar's Signature				header W. K. & Thy res		March 14, 200	98 			
Ottale	1				re, MD 21201					
Registrar MAR 2 5 2008										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 45 AM 02 20 MAN 2008 NO /Medical 4a. Facility Name (It not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner KALTIMORE TIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Days PALTIMORE, ALL Months Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural', or Items 23a or 28a-f show dical Examiner must be notified at 1 □ Yes 2 No Director mei 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No IFYes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Appendix 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SSMar ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Jass</u>Mar chnis 20b. Place of Disposition (Name of Baltimore, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) ford Rd 21. Signature of Funeral Service Dicenses BALTIMORE, MD Kimbe Evans Funeral Cha e, or complex tion, that cause if the death. Do not enter the mode of dying, such as cardial or respiratory arrest List only in cause on each line. Approximate Interval Between Onset and Death 23a. Pirt1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** Mean /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical the as attending p for use as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) P.O. the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed Le certificate 2 11No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to edical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of De 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 2008 **Physician** MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BELAIR ELAIRHEALTHAN KETHABILIT TATIEN CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 1 F **Director** BALTIMORE MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director TIMORE Deni 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname, Be 2 should be fi and Mental F ပ 20 19a, Informant's Name/Relationship (Type, Print) 19h Mailing Address (Street and Number or Rural Boute Number Baltimore, Pages 1 g 1 ☐ Bunal 2 ☐ Cremation 3 ☐ R
4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service inclutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pro-cause on each line. 23a. Part 1. Enter the dise shock, or heart failur Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Me 29 /Medical a consequence of): Examiner 31021 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has death? 1 ☐ Yes 1□ Yes 2⊡ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 20 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 1 - Natural 5 Pending investigation Iniury 1 Tes 2 □ No 2 Accident completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier another and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) NAU 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Facility Name (If not institution, give street and number, **Examiner** 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**7**F Months MD 6D **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify 4 Divorced Completed by 3 Widowed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pache Baltimure eyears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) a Himure, MD 21206 trank whitehoad err 20a. Method of Disposition 20c. Location - City or 1 Burial 2 □ Cremation 3 ☐Removal from State Orange, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8728Libertu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Oyeur Die t (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 687605 Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the irrector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed<sup>a</sup> or Attending Physician: ours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury
(Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

12

State Registrar 31. Date filed (Month

101

mpleted cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month : 05am 4c County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UUStminst-If Under 1 Year | If Under 24 Hrs. 17 Social Security Number Age (In yrs. last birthday Birthplace (State or Foreign Country) Min 1∑M 2□ F 214-36-8709 Yrs. 69 Nov Maryland Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ₩Yes 2 □ No If Yes, Give Year or Dates: 157-6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white **'**57**-**61 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) barber cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Esty Wilder Elizabeth Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Wilder/spouse 109 Schoolhouse Road Sykesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 \ Donation 5 □ Other (Specify) 21. Signature of Financial Privice Licensee A Nade State Anatomy Board 655 W. Baltimore Street Director del 1 Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 10 years Immediate Cause (Final End stage emphysema disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 22 No 2 No 1 Yes 1 Tyes 26. Place of Death (Check only one) Hospital: Other: 4M Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

ed by the attending physicien and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 cete has been signed by page 2 should be detack this certificete has r death. ector: After this certifice by the funeral director, p ours after death.

neral Director: A
filled in by the fu within 24 hours a To the Funeral C completely filled

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show

**Funeral Director** 

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Examiner

Physician/Medical

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Certification: To

Medical

th and Mental Hygiene. 27 is marked other than "naturel", or tiems 23s or 28s-1 shov traumatic event, the Modical Examinat must be notilied at

permit. Pages 1 and 2 should be filed within 72 hours after death with It Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 2 and Injury or other traumatic event, the Modical Examinar must be no 2006.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

the Maryland

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus 25. Was case referred to medical 1 ☐ Yes 2X No 1 Natural 2 Accident

27. Manner of Death 3 Suicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D17040

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

Bundson W 30. Name and address of person who cyrodeted cause of death (Item 23a) (Type, Print)

Lanham, M.D. 215 Washington Heights Medical Center, Howard G.

State Registrar

31. Date filed (Month, Day, Year) MAR 25





Westminster, MD 21157

March 17, 2008

		1	For State Registrar amend #17	State of M Per Ana I		-						gienę Reg. No.		094	82
Physic /Med		1	Decedent's Name (First, Middle, La McDonald Whitloo								2. Date of Dea Month March	Day	2008	3. Time of 1:23	
Exam		4:	a. Fecility Name (If not institution, giv 10 Manor Circle	44	r)				Location o				County of Deat		
Funera Directo			Social Security Number 6. S 214-14-0938	Sex 7.7	Age (In yrs. 64	/ast birthday) Yrs.		Days	If Under Hours	Min.	8. Date of Birtl (Month, Day Dec 7,	1 943	9. Birti Co Mary	hplace (State or untry) Land	Foreign
Maryland -1 ehow	tor	1	Sual Residence of Decedent   Oa. State   10b. County   MD   Montgo	mary	10c. Cit	ty, Town or Lo	ma P	ark						10d. Inside Cit	-
with the	Direc	1	0e. Street and Number  10 manor Circle			Tako	_	p Code	20912	)		10g. Citiz	en of What Co	untry?	
is 1 and 2 should be filed within 72 hours effer death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Enant at must be notified at	Completed by Funeral Director	1	1. Marital Status  1. Never Married 2. Married  3. Widowed 4. W Divorced	12. Was Deceder Armed Force 1  Yes 2 If Yes, Give Year or Date:	s? XNo		Was Dec If Yes, sp			igin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.	
nd within 72 hours eff gjene er than "natural", or the Modical Exerci-	pieted	_	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4c	r 5+)	16a. Dece (Give life.	dent's Us kind of w DO NOT	ark dane d	<i>turina</i> mos	t of worki	ng	16b. Kir	nd of Business/	Industry	
MICE YIGHTON Z. I nd 2 should be filed wi th and Mental Hygien 27 is marked other th traumatic event, the	To Be Con	1	12 7. Father's Name (First, Middle, Last, McDonald, McDonald Whitlo	5+ ock Sr			hemi	st			(First, Middle,		mmercia Sumame)	1	
and 2 shousalth and Malth are traumated.			9a. Informant's Name/Relationship ( Helen Whitlock/s	Type, Print)		1			and Numbe	er or Rura	German	-		Zip Code)	
Deficiency permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other			0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Special	y in stat	e	Place of Dispo cemetery, crei	matory or	other plac			ate		cation - City or		
Depart Import		1	21. Signature of Euneral Scool Lices RON 3	2120			1timore	Street							
Physiciar /Medica Examine		1	shotk, or heart failure. List only mmediate Cause (Final disease or condition resulting in death)	a. CHRONZ  Due to (or a Due to	line.  COBS as a consec	7 P. U. 7 quence of):								Interval Bett Onset and I SYEA	Death
eath certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	r	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Diseese or injury hat initiated events esulting in death) Last	cDue to (or a	as a consec	quence of):									
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w requires thet been signed b	þ	"	art II. Other significant conditions		but not res	sulting in the u	inderlying	cause giv	en in Part I	l. ——				othe cause of d robably 4 □U	
The hard	Completed	-							_		24a. Was autop perio 1 🗆 Yes	nsy med?	24b. Were au prior to death?	utopsy findings completion of c	available ause of
Physician: Trips certificentral director, p	To Be		25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpa	itient 2	] ER/Outpatie	nt 3 🗆 🛭	Oth			n <i>(Check only o</i> me 5 ☐ Resid		S □Other (Spe	icify)	
Afte fune			27. Manner of Death  1 Matural 5 Pending 2 Accident investigatio		njury Day Year)	28b. Time o Injury	M	28c. Injur Wor 1 🗌			28d. Describe h	<del></del>			
	Certification:		3 Suicide 6 Could not be determined	building,	etc. (Speci	<i>fy)</i>					28f. Location (\$ City or Tov	vn, State,	)		ber,
To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medical	1		hysician: To the be miner: On the basis and manner	of examina										i)
To the within 2 To the complet	M	4	29b. Signature and title of certifier	mar u	0		2		e number	O	4		e signed (Mont	th, Dey, Year) , 2009	
		3	30. Name and address of person who $FRNNKJ$ . $M$	completed cause of	f death (Ite	m 23a) (Type, 20 FR	Print)	ICK	Road	M21.	3 6AZ	1116.	RIBURG	i, Mp.	2057
S Regis	tate		B1. Date filed (Month, Day, Year) MAR 2 5 20	320Reg	strar's Sign	ature	a die								

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			For State Registrar	State of Ma	aryland	•	artment of F ctificate of			iene <sub>eg. No.</sub> 2 () (	8	09483
	Physicia /Medic		1. Decedent's Name (First, Middle, L William		est				2. Date of Deat Month March 1:	Day Y	ear (	3. Time of Death 6:45 A M
	Examin Funeral Director		4a. Facility Name (If not institution, g  Maryland Mason: 5. Social Security Number  220-09-1755	C Home Sex 7. Age	9 (In yrs. la	a <i>st birthd</i> ay) Yrs.		r Location of Death ysville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 20,	Year)	imor	ce (State or Foreign y)
	Maryland f show ed at	or	Usual Residence of Decedent  10a. State 10b. County  Marvland Baltin		10c. City	, Town or Lo	cation				100	d. Inside City Limits 1 □ Yes 2 🛣 No
	with the a or 28a-be notif	Directo	10e. Street and Number			COCKE	10f. Zip Code	120	1	0g. Citizen of Wh		y?
5-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral	300 Internationa  11. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?		}	210 Was Decedent of H If Yes, specify Cub: 1□Yes 2☒No	ISO  Ispanic Origin? (S an, Mexican, Puert  Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race Black, Specify:		tc.
215-0	nin 72 ho s. in "natur Medical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5	i+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Busi	ness/Indu	ustry
21	e filed with Hygiene other that vent, the	Com	08	n/a	,	Mai	ntenance		es /Cimt Middle I	Utili		
Maryland	e d stal	To Be	17. Father's Name ( <i>First, Middle, La.</i>	W	est	T		N	orma	McGu	ire	
<u>ი</u>	s 1 and 2 if Health a ftem 27 is other trai		19a. Informant's Name/Relationship  Margaret Hall/I  20a. Method of Disposition	Niece	20b. Pl	4039	•	ica Drive	, Baltim		y1an	d 21222
Baltimore,	Pages thent of tant: If its jury or o		1 X Bunal 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	cify		ing H	ill Cemet	ery 3/1	7/08	Easton,	Mar	yland
Bail	permit. Page Department or Important: If any Injury or once.		21. Signatule of Funeral Service Lic Bryan W. Cla	tery			10 W. Pac	ineral Ho <u>lonia Roa</u>	d, Timon	ium, MD	210	93
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Pinal disease or condition	mplications that caused ly one cause on each lir	the death	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
68760,	/Medical Examiner physician and physician and the priral-transit	lical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as.  Due to (or as.  Due to (or as.  Due to (or as.		uence of):	s Dises	ν				
O. Box 6	The law requires that the death certificate by the has been signed by the attending physic age 2 should be detached for use as the by	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[	Ectopic pregnanc Other (specify)	у		23d. Date Mont		y Day Year
rds, P.	w requires that the di been signed by the should be detached	þ	Part II. Other significant conditions	Disere, M	ut not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tol		oute to the	e cause of death?
Vital Records,	The law recate has been	Completed	loss- Very ge	nene, Hy	peil	erm	, Anere	ii,	24a. Was a autops perfor 1∐ Yes	sy pr med? de	for to come ath?	sy findings available ipletion of cause of
Vita	siclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		ED/Outrotion	oth	201.	ath (Check only on		(0 )	
Division or	To the Hospital or Attending Physician: The law Within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Day	ry	28b. Time o Injury	f 28c. Inju Wo		forme 5 ☐ Reside 28d. Describe he	ow injury occurre		)
Divisi	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not determine				reet, factory, office		28f. Location (S. City or Town	treet and Numbe n, State)	r or Rural	Route Number,
	e Hospita 124 hours e Funera letety fille	Medical C		Physician: To the best aminer: On the basis of and manner sta	f examinat							
	To th withir To th comp	Me	29b. Signature and title of certifier	> .			29c. Licens	se number	2	9d. Date signed	_	Day, Year)
)	111		30. Name and address of person w	o completed cause of d	eath (Item	23a) (Type,	Print)	31464		3/13/0	ช	
	41		Po Bant UBert 31. Date filed (Month, Day, Year)	5, MD. 350	8 Bar's Signa	auch 5	T Ball	5, Mil	21224			
Dh	Sta Registr 	ar	MAR 2 5 20	008 Janeyisti	ar o olyrid		S.		,			
211	17 NOV 1/2	001				-						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 Physician MARCH 2008 4:55P PHYLLIS WOLFE /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

М

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

**Funeral** Director

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

C1	BRIGHTON	N GARDI	ENS OF PI	KESVILL	E	PIKE	SVIL	LE			BALT	IMORE	
	5. Social Security No. 216-09-6		6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs	s. <i>last birthd</i> ay, Yrs.	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da	, Year) 1912	9. Birthpl Count	ace (State or Foreign
	Usual Residence of			95						0//13	/1912		MD MD
	10a. State	10b. County		10c. C	City, Town or Lo	ocation						10	Od. Inside City Limits
ctor	MD	BAL <sup>-</sup>	TIMORE		PIKESV	ILLE							1 ☐ Yes 2 🛣 No
Oire	10e. Street and Nun	nber				10f. Zij	p Code				10g. Citizen of	f What Count	try?
] je	17 BRANC	CHWOOD	COURT				2	1208				USA	
ıneı	11. Marital Status		12. Was De Armed F	cedent Ever in	U.S. 13.	Was Dece	dent of H	ispanic Ori an, Mexicar	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	- 14. Ra	ace - America ack, White, e	
γFι	1 ☐ Never Marrie	_	If Yes. 0	; 2[X]No ∃ive		1 ☐ Yes		Specify:				ify: WHI	
q p	3 X Widowed		1	Dates:	10. 5			-1'					
ete	(Speci	15. Deceden ify only highe	it's Education est grade completed	1)	16a. Dece	dent's Usu kind of wo DO NOT u	nai Occup ork done (	ation during mos	t of workir	ng	16b. Kind of	Business/Ind	ustry
Be Completed by Funeral Director	Elementary/Secor	ndary (0-12)	College	(1-4or 5+)	line.		OMEM					OWN	HOME
C	17. Father's Name (	First, Middle,	Last)		'			18. Mothe	r's Name	(First, Middle,	Maiden Surna	ame)	
To B	CHARLE	ES			JAFFI	Ξ		MAM	ΙE			MILH	EISER
	19a. Informant's Na	me/Relations	ship (Type. Print)		19b. Maili	ng Addres	s (Street	and Numbe	er or Rura	l Route Numb	er, City or Tow	n, State, Zip	Code)
	MARIAN	SHUMAN	N / DAUGH	TER	17 E	BRANCI	100WH	cou	RT.	PIKESV	ILLE, N	4D 21	208
	20a. Method of Disp		0. 🗆 🗅		Place of Disposer	osition (Na	me of other plac	ce)	D	ate	20c. Location	- City or To	wn, State
	4 Donation		3 □Removal fror Specify)	n State	MEMOR.	TAL P.	ARK	0.	3/23	/2008	RANDAL	LSTOW	N. MD
Ì	21. Signature	neral Service	Licensee	•		2. Name a					SON & I		
	404	u /lla	who-		1 8	3900	REIS	TERST					MD 21208
	23a. Part1. Enter the shock, or hear	ne disease, or nt failure. List	complications that only one cause on	caused the dea	ath. Do not en	ter the mo	de of dyir	ng, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (I	Final		roselei									Onset and Death
	resulting in death)			o (or as a conse		27541	0.		. ,			- 1	
	Sequentially list cor	aditions	b										
iner	cause. Enter Under	rlying -	Chaf	(or as a ponse	quenne of):								
am	Cause (Disease or i that initiated events resulting in death) L		c	,									
<u> </u>	rooding in doddin E	.uot	Due to	o (or as a conse	equence or):								
dice			d			-							<del></del>
by Physician/Medical Examiner	IF FEMALE:		23c If yes o	utcome pf preg	nancy						004 5		
cian	23b. Was decedent in the past 12 1 Yes 2		1 ☐ Live	birth 2 Fe	tal death 3	⊒Ectopic p ⊒ Other <i>(s</i>		1				Date of delive Month	Day Year
ysi	1  Yes 2 9  Unknown	No	9□Unk										
y P	Part II. Other signif	icant conditi	ons contributing to	death but not re	esulting in the u	anderlying o	cause giv	en in Part I	,	23e. Did t	obacco use co	ntribute to th	e cause of death?
	Dementi	ia								1 🗆	Yes 2 □ No	3 ☐ Prob	ably 4 Unknown
lete	, ,									24a. Was	an 24b	o. Were autor	osy findings available
шć										auto perfo	osy ormed?	prior to cor death?	npletion of cause of
Be Completed	25. Was case referr	red to medica	1					26 Place	of Death	1□ Yes		1∐Yes	2 □ No
To B	examiner? 1 □ Yes 2 <b>X</b>		Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 □ D	OA Oth				dence 6 🗆 O	other (Snecifi	()
Ë	27. Manner of Death	n	28a. Dat	e of Injury onth, Day Year)	28b. Time o		28c. Injur Wor				how injury occi		<u> </u>
atio	1 Natural 2 ☐ Accident	5 Pendir investi	ig .	niii, Day Tear)	Injury	М		Yes 2	No				
iţi	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	nined 28e. Plac	ce of injury - At Iding, etc. (Spec	home, farm, st	reet, factor	y, office		2	28f. Location (		nber or Rura	l Route Number,
Cert	5				,					ony 0, 10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Medical Certification:	29a. Certifier (Check only one)	1 Certifyii 2 Medical	ng Physician: To the Examiner: On the and ma	he best of my kr basis of examinanner stated.	nowledge, dea nation and/or i	th occurred	d at the tir	ne, date ar opinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) and i date and place	manner as st e, and due to	ated. the cause(s)
Me	29b. Signature and		_			29	c. Licens	e number			29d. Date sigr	ned (Month,	Day, Year)
	► na	ien L.	Bulit	, M.D.			170	0586	76		March	21,2	DD &
	30. Name and addre											_	
	karen L			as old		Road	, 54	/te 35	21, 8	seil time	ove, M	0 2/2	205
te	31. Date filed (Mont	th, Day, Year)	32.	Registrar's Sig									
ar	M	AR 25	2008	Page 2	1. A	Balley	ÿ		-				

DHMH 17 Rev 1/2001

Sta Regist

Division or Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0036

fshow

attending physician requires that the death certificate be as the detached page 2 should certificate has After this Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

Bruce S. Cooper

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bruce S. Cooper 1500 Forest Glen Rd. Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

03-21-08

29c. License number

D23863

Registrar

31. Date filed (Month, Day, Year) MAR 2.5 2008

29b. Signature and title of certifier

32. Begistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 08 2:30 Ам Andrew Joseph Yourik 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale Baltimore Franklin Square Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 01/29/1921 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours XXM 2□F West Virginia 87 218-03-1015 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Baltimore 1 □Yes 2XTXNo Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 13 Cardinal Lane U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1943 XXYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No 1945 Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Yourik Elizabeth Virginia Churilla 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Yourik (Daughter) 424 Arroyo Parkway, Ormond Beach, Florida 32174 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus03/27/2008 Baltimore, Maryland <sup>22. Name and Address of Facility</sup> Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate ause (Final disease or ondition resulting in eath) Bacteremio le days Due to (or as a consequence of) ritonitis le dav Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Perforated VISCUS Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy

**Physician** /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

ms 23a or 7

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner m.

. Pages 1 and 2 should be fill ment of Health and Mental Hiant; If item 27 Is marked oth

Baltimore, Maryland 21215-0036

Yourik, Andrew

Director

Funeral

Completed by

Be

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72 hours after death with the Maryland

requires that the death certificate be executed burial-trans and as the been signed by the same should be detached page 2; or Attending Physician:

director, filled in by the funeral After after death

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of c				Month Day Year
Part II. Other significant conditions co	*	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?  2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1∐ Yes 2 ☑	
25. Was case referred to medical			26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ [	Othori		6 ☐Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	and the second s	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specifical)	ome, farm, street, facto fy)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)

29c. License number

D0063131

29d. Date signed (Month, Day, Year) March, 23, 2008

21237

MD

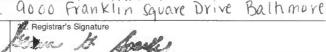
within 24 hours a To the Hospital

> State Registrar

NIRISH S. SHAH , MD 31. Date filed (Month, Day, Year) MAR 2 5 2008

X.

29b, Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 3:50 PM Burton ZIMMERMAN 2008 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTHWEST HOSPITAL PANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 □ F 78 119-20-8464 Director NewJersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Mary land Baltimore Owings 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in South Tollgate Road 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Xyes 2 No IFYes, Give Year or Dates: Korean War 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) High School Biology Teacher Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Samuel Stack Zimmerman Te ssie ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter P.O.A. Jennifer Spain 103 South Tollgate Road Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Reals tra March 20, 2008 Hanover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 1522 Connelley Drive suite P. Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and is the burial-transit the death curtificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical ttending pl IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐Unknown 9 ☐Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 🔽 No 1 ☐ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 certificate 1∐ Yes 2 1 No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 210 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manney f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director; A

bletely filled in by the fu investigation hours after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30 Name all

MANDEEP

31. Date filed (Month, Day,

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ROAD RANDALLOTOW

of person who completed cause of death (Item 23a) (Type, Print)

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			Oh and a second of the second	partment of Health and Me ertificate of Death	Reg. N	2008 03488
	Physic /Medi Examii	cal.	John Anthony Ascosi, Sr.  4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park	07 O	3. Time of Death C. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 219-54-8666 1 1 M 2 F 7. Age (In yrs. last birthda Yrs. 58	Months Days Hours Min.	Date of Birth (Month, Day, Yea	
nore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ant: If item 27 Ie marked other than "natural", or Items 23a or 28a-f show any or other traumatic avant. The Madical Examiner must be notified at	To Be Completed by Funeral Director	10a. State   10b. County   10c. City, Town or	Iver Spring  10f. Zip Code  20910  Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rice of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rice of Yes, specify:  1□ Yes 2☑ No Specify:  edent's Usual Occupation most of working of Work done during most of working DO NOT use retired  Piano Refinisher  18. Mother's Name (Formula Formula	fy Yes or Nocan, etc.)  16b.  Pi First, Middle, Maide Marie Cam Route Number, City e, Silver e 20c.	panella v or Town, State, Zip Code) Spring, MD 20910 Location - City or Town, State
	cate be executed  The burial transit  The buri	l Examiner	21. Signature of Funeral Service Licensee	itan Crematory 2008 22. Name and Address of Facility Francis J. Collins F 500 University Blvd, nter the mode of dying, such as cardiac or re	Funeral H W. Silv espiratory arrest,	er Spring MD 20901 Approximate Interval Between
cords, P.O. Box 68760,	v requires that the death certifi. been signed by the attending f should be detached for use as	leted by Physician/Medical		□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	1 ☐ Yes 2	23d. Date of delivery Month Day Year  use contribute to the cause of death?  2 No 3 Probably 4
on of Vital Record	ding Physician: n. After this certifice funeral director, i	tion; To Be Completed	25. Was case referred to medical examiner?  1	of 28c. Injury at 28d Work?		6 ☐Other (Specify)
Division of	Hospital or 4 hours afte Funaral Dir tely filled in	edicai Certification:	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, si building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the bass of my knowledge, deal and manner stated	th occurred at the time, date and place, and	City or Town, Star	c) and marroes as stated
•	To the within 2 To the comple	Med	29b) Signature and title of certifier  What was a signature and ti	29c. License number 35427	29d. Di	ate signed (Month, Day, Year)
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 1 2008  32. Degistrar's Signature	00 Canal Ne, T	MECUNA	PARK, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jeanette Elizabeth рм 07, Albergo March 2008 12:15 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18018 Red Rocks Drive Germantown Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Months Days Hours Director 102-44-1462 56 Dec. New York 6, 1951 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18018 Red Rocks Drive 20874 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo à Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hotel Industry 12 Hotel Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Calise Angela ဥ Rosseti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Epifanio J. Albergo - Spouse 18018 Red Rocks Drive, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 3/11/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** small cell carcinoma of bladder months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy performe 2 💢 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending investigation 1 X Natural (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Puneral Director; filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To th. To the Fu (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joseph m. Hagzerty no D32407 3/7/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D., 9707 Medical Center Drive, Suite 300, Rockville, Md 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 11 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 6, 2008 2:40 P M Richard L. Abbett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 4/29/1931 9. Birthplace (State or Foreign Country) New York 6. Sex **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Min 1 X M 2 □ F Director 126-22-5607 76 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show at notified 1 X Yes 2 ☐ No Director MDMontgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 20906 3210 N. Leisure World Blvd. #709 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No Army If Yes, Give Year or Dates: '55-'57 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify ò Specify: 3 Widowed 4 Divorced White 'natural'; Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Optometrist Optometry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Spencer Abbett 2 Rena Heyman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) Roberta A. Abbett - wife 3210 N. Leisure World Blvd.#709 Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 3/9/08 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. Oonald ( tottlemucr 1170 Rockville Pike Rockville, Md 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CLL /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of): Examiner and I-transit death certificate be executed resulting in death) Last physician ar Due to (or as a consequence of): Box 68760 Physician/Medical as attending | IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I signed by the a d be detached f ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 X No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2 No Hospital: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dire ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Genevieve Wroblewski, 31. Date filed (Month, Day, Year) MAR 1 1

29b. Signature and fille of certifier

29a. Certifie (Check on one)



and magner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

March 7, 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Daniel aka Raymond Edward BROOKS Sr. March 11, 2008 1:45 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Yrs. Director 410-24-7675 83 July 25, 1924 Tennessee Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director WV Berkeley Falling Waters 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 153 Dove Lane 25419 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married 'naturai", or 1 ☐ Yes 2 🗓 No Specify: white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) binderman book publishing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Bell Brooks Gertie Ellison Honeycutt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irma O'Kain Brooks - wife 153 Dove Lane, Falling Waters, West Virginia 25419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/18/08 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Euneral Service Licensee 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician KESPIRATORT /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed MYOCARDIA INFARCTION physician and the burial-tran Due to (or as a consequence of): Physician/Medical SERTIC SHOCK as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FALLUNG Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an COAGULOPATH certificate has autopsy 1□ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/12/2008 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54-12+1 DAV D Any AILO WINEDIN 251 ANTIETAM ST. HALLELITON N MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 13 2008 Registrar

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

Registrar

MAR

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** 12:07 2008 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore BaltimoreCity Johns Hopkins 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12-19-1967 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Wilm., DE Director 40 222-56-6327 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at DE NewCastle Newark 11X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 27 Teal Circle 19702 Funeral Newark USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the Jones. the 12 laborer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvin Kendall Louise (Carter) Smith 2 Vivian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daria I. Carter-Jones 13-M Kimberton Dr. Newark, DE 19713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 □Removal from State 3-11-2008 Chestertwp, PA 4 ☐ Donation 5 Other (Specify) Haven Crematory 21. Signature of Junera The House of Wright Mortuary 208 E. 35th St. Wilm., DE 19802 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage days /Medical Due to (or as a c equence of) Examiner Sequentially list conditions, any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a gonsequence of) Examine requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospira.
within 24 hours after
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

RES-000

Johns Hopkins Hospital, 600 N. Wolfe St., Bultimore, MD 21287

March 1, 2008

Medical Doctor

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item 7 State of Maryla State Registrar WCHD/SH 3/13/08 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Dav **Physician** Madeline н. DeMottez March 2008 11:50 p<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Beverly Healthcare Washington 9. Birthplace (Sta. Country) Hagerstown er1 Year | If Under 2 If Under Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Days Hours Min 1 □ M 2 X F 91 Director 214-09-4411 MD 1/4/1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 464 McDowell Ave. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel (Shaffer) DeMottez 2 Dominic DeMottez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald J. Marani Nephew 81 High Ridge Rd, Delta PA 17314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3-14-2008 Smithsburg, MD 21. Signature | Funeral Service Homsee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Zhue 9 4000 neu /Medical Due to (or as a const uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3□ D0A After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) Street Hagaston MU2190

State Registrar 31. Date filed (Month, Day, Year)

MAR 13

2008

DHMH 17 Rev 1/2001

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32. Registrar's Signature

		,	1 - For State Registrar	State of M	arylan		artment rtificate			and M	•	giene Reg. No.	20	08	094	95
3	Physic	an	1. Decedent's Name (First, Middle, Las	·							2. Date of De Month	Day		Year	3. Time of Do	
	/Medi Exami		4a. Facility Name (If not institution, give	D. Daetwyle			4b. City. T	Fown, or	Location o	f Death	March	07		2008 of Death	1:30	) PIM
	LAdiiii	ICI	10117 Brock D						lver Sp			Montgomery				
	Funeral		Social Security Number     6. Security Number		ge (In yrs.	last birthday)	If Under		If Under 2		8. Date of Bir (Month, Da	th v. Year)			ace (State or F	Foreign
L	Director		220-04-3942	□M 2⊠F	91	Yrs.	World	Duyo	riouis	IVIII I.	February		917	Coun	Haiti	i
	land bw t		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	Od. Inside City	Limits
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	er dea tems ner m	Funeral	11. Marital Status	12. Was Decedent Armed Forces'	,	.S. 13.1	Was Decede	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	)-		e - America k, White, e		
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Ma	d 2 sl th an th sn 7 is r traur		19a. Informant's Name/Relationship (T) Monique H. Granado	. ,		Ĭ.					I Route Numb	-			Code)	
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ê E	Page: ent of nt: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		- 1	t Lincol			1	03/11	L/2008	Rront	trood	Mosess	land	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licens		1 101	22	. Name and	Addres	s of Facility	/				, Mary	Tallu	
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8760,	Physician / Medical Examiner ophysician and physician and the prutal-transit the prutal-transit ophysician and the prutal-transit ophysician and the prutal-transit ophysician and the protection of the protectio	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. Lister of the shock		ed A1z a consequ a consequ	theimer': uence of): uence of):									Approximate Interval Betwe Onset and Dea	ern ath
P.O. Box 68	eath certifi attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3□	]Ectopic pre ] Other (spe					2	3d. Date Mor	e of delive	ry Day Yea	ar
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	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the best ner: On the basis of and manner at	f_examina	wledge, death tion and/or inv	occurred a vestigation,	t the tim	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and mar place, a	nner as sta and due to	ated. the cause(s)	
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			30. Name and address of person who co			, , , , .	,	to 1/	ηΛ P.~-	olered 1	1 o Mo1	land o	) 10 c r			
	Sta	te.	Genevieve Wroblewshi 31. Date filed (Month, Day, Year)	, M.D., 135 32 Registr	ar's Signal	ture		LE I	, KOC	-KV11.	ie, mary	rand 2	20000			
67	Registr	-	MAR 1 1 200		A	los	all I									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item# State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Cecil Co. Certificate of Death 03/18/08 riw Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 2008 Jackie Elaine Doberstein 12:35 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlestown
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 416 Chesapeake Road Cecil Date of Birth Valune Day, Valune 14, 1963 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2√7F 159-60-0116 44 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show other treumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Cecil Charlestown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 416 Chesapeake Road 21914 United States or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 275 No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No White Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Packer Moving Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred J. Doberstein Jackie A. Allen ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Ie m eny Injury or other treum 900. David Apgar / Companion 416 Chesapeake Road, Charlestown, Maryland 21914 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State March 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11, 2008 Mayerdale Crematory Newark, Delaware 21. Signature of Fun and Service Consee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final un Khown **Physician** orlas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown sete hes been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Pros 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes 1 Yes 2 No 2 NO 1 ☐ Yes Division of Vital Hospital or Attending Physician: 4 hours efter death. Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 HNatural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral I 29a. Certifier t 🕒 Cartfying Physician: To the best of my knowledge, death conured at the time, date and plane, and due to the reuse(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Dimonsan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 1 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ()3()DM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AA 8. Date of Birth (Month, Day, Year 10/1/1928 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** Days Months Hours 1□ M 2√X 218-24-9186 Yrs 79 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exercise mast to notified at 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If I tiem 27 is marked other then " any injury or other traumer." 35 Milkshake Lane 21403 United States Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) Licensed Practical Nurse Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Squirrel Cecelia Magruder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Bullock/Daughter 10851 Jones Creek Circle, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/7/08 Baltimore Crematory Baltimore, Maryland \* 4 □ Donation 5 □ Other (Specify) 21 Signator of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke Of Gloucester St., Annapolis, MD 21401 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULKAL 6-01. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ₹ o 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed 2□ No certificate 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 □ No

Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: After this death. Director: after 24 hours a e Funerai I within 2

> State Registrar

2

29b. Signature and title of certifier

6 Could not be

3 Suicide

29a. Certifier

icai

4 Homicide

(Check only one)

29c. License number 2636

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 1. Nonh 2100 31. Date filed Month,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Resstrar's Signature Day, Year) MAR 0 2008

DHMH 17 Rev 1/2001

Registrar

MAR 11

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2008 04:00 AM Mary Elizabeth Ferguson March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 114 Grandview Avenue North East Cecil 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 X F Director 215-18-9729 88 June 7, 1919 Maryland Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Cecil North East Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Anti frem 27 is marked other than "natural", or items 23a or marked other than "natural", or items must be a ruy or other traumatic event, the Marical Examiner must be a 78 Hillcrest Lane 21901 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: White Completed by 3 ☐ Widowed 4 🙀 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Veteran's Administration Elementary Secondary (0-12) College (1-4or 5+) Mail Room Government Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Ferguson 2 Mary E. Hartenstine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Preston / Niece 114 Grandview Avenue, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once, North East Methodist 14, 2008 North EAst, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funeral Service Licen-127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myocardial Infarction unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jus to (or as a consequence of) Examine physician and as the burial-trans Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ed by the 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s autopsy performed? 1□ Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Hours Grand view Avenue her Specify 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 X Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D0059903

March 10, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pamela LeClaire, MD, 102 East Cecil Avenue, North East, Maryland

31. Date filed (Month, Day, Year) MAR 1 1 2008

(Check only one)



			for State Registrar		Olale of	mai yiaii	-	rtificate of	Death	Wentarri	Reg. N	0000		500
	Dharaisi		1. Decedent's Name (First,	Middle, Last	)	.,				2. Date of D Month		Year Veer	3. Time	of Death
	Physici /Medi		Henrietta			Gatt	i			March	8,	2008	5:20	) P M
100	Examir		4a. Facility Name (If not inst	tution, give	street and numb	oer)		4b. City, Town,	or Location of Dea	ath	4	lc. County of Dea	ıth	
			Brighton Gar					North B				Montgo		
ŀ	Funeral Director		5. Social Security Number 216-46-5912		х ]м 2 <b>X</b> ] F	. Age (In yrs. 93	last birthday) Yrs.	Months Days	If Under 24 Hr Hours Mir		ay, Yea	9. Birthplace (State or Foreign Country) Virginia		
	and and		Usual Residence of Decede  10a. State 10b. Co			10c. City	, Town or Lo	ocation					10d. Inside	City Limits
	Manyl f sho led al	ō		ntgome	erv	No	rth Be	thesda						es 2 No
	the 1 28a- notif	rect	10e. Street and Number					10f. Zip Code			10g. C	Citizen of What C	ountry?	
	3a or	Funeral Director	5550 Tuckern	an La	ne				0852			U.S.A.	,	
	death	ner	11. Marital Status		12. Was Deced Armed Ford	ent Ever in U.	S. 13.		Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or N		14. Race - Ame		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Dive		1 ☐ Yes 2 If Yes, Give Year or Dat	i⊠ No	i	1 ☐ Yes 2 No		ano nican, etc.)		Black, Whi	white	
5-0	72 hc natu	Be Completed by	15. Dec (Specify only i	edent's Edu	ication le completed)		16a. Dece	dent's Usual Occu	ipation e durina most of w	orkina	16b.	Kind of Business	/Industry	
2	within ene. than "	Jd w	Elementary/Secondary (0-	· · ·	College (1-4	lor 5+)			e during most of w ed)	onung ,		,		
2	led w tygie her tl nt, th	ខ	12 17. Father's Name (First, Mi				Ho	omemaker	40. Mathada Na		1	own home	2	
anc	t be find he ed ot	Be	Frank M. Arm		nV					<sub>ame (First, Middle</sub> etta Lee				
Ž	hould Me mark matic	ျှ	19a. Informant's Name/Rela				19h Maili	nn Address (Stree	et and Number or I				Zin Codo)	
Maryland	nd 2 should be filed within alth and Mental Hygiene. 27 Is marked other than r traumatic event, the Me		Richard S. G			on	1		Ct. Rock					
ā	permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other it	1	20a. Method of Disposition			20b. P	1	osition (Name of matory or other pla		Date		Location - City or		
Baltimore,	Page lent o nt: #		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			ate		's Cemete	1 1/1 24 7	ch 12, 2008	Was	hington	. D.C.	
alti	permit. Departm Importa any Inju	l ï	21. Signature of Funeral Se			1000			ess of Facility De				, 2.0.	
a	De la la la la la la la la la la la la la	1 0	Muca.	# 20	the second		22	222 Wisco	onsin Ave	e., N.W.	Was	hington	D.C.	20007
п			23a. Part1. Enter the diseas shock, or heart failure.	e, or compl List only o	lications that cau	ised the death th line.	n. Do not en	ter the mode of dy	ring, such as cardi	ac or respiratory	arrest,		Approxin Interval E	Between
-	Physician	i i	Immediate Cause (Final disease or condition		Cong	estive	Heart	Failure					Onset ar	d Death
7	/Medical Examiner		resulting in death)		Due to (or	as a consequ	uence of):							
	Lamine	_	Sequentially list conditions,		0	iomyopa as a consequ								
	ted	Examiner	cause Enter Underlying Cause (Disease or injury	~			nince orp							
	xecu al-trai	xar	that initiated events resulting in death) Last		v	ritis as a consequ	ence of):							
68760,	certificate be executed iding physician and ise as the burial-transit	cal			<sub>d.</sub> Нуре	rtensi	on							
		Medical												
.O. Box	death e atter id for u	Physician/№	IF FEMALE: 23b. Was decedent pregnat in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	IL Y		th 2 ☐ Fetal nt at time of d	death 3	Ectopic pregnand Other (specify)	су			23d. Date of de Month	livery Day	Year
Д	s that the ned by th detache	by Pr	Part II. Other significant co	nditions co	ntributing to dea	th but not resu	ılting in the u	nderlying cause gi	iven in Part I.	23e. Did	tobacco	use contribute t	o the cause o	of death?
rds	w requires been sign should be									. 10	Yes	2 <b>⊠</b> No 3□ P	robably 4	Unknown
Records,	N P	Completed								24a. Was		24b. Were a	utopsy finding	js available
Ä	The I	E O							·	- auto perl 1∐ Yes	ormed?	death?	completion of s 2 □ No	t cause of
ita	ian: ertifica	Be C	25. Was case referred to me examiner?	dical					26. Place of De	eath Check onl		10   12   10	2 2 110	
or Vital	Physician: this certific	10	1 Yes 2⊠ No	1		atient 2	ER/Outpatier	nt 3□ DOA Ot	her: 4K Nursing	Home 5 ☐ Res	idence	6 □Other (Spe	ecify)	
n o	ffel ffel	on:	27. Manner of Death  1 ☑ Natural 5 ☐ P	ending	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time o Injury	Wo		28d. Describe	how inj	jury occurred		
Sio	Attending r death. ector: After	cati	Z L Moordon	vestigation ould not be	On Plans	Cinium Addin			]Yes 2□No	200				
Division	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:		etermined	building	, etc. <i>(Specif</i> )	me, tarm, sti	eet, factory, office		28f. Location City or To	(Street a wn, Sta	and Number or R ate)	ural Route N	umber,
	spital		29a. Certifier 1 CA	tifying Phy	sician: To the b	est of my kno	wledge, deat	h occurred at the	time, date and pla	ce, and due to the	e cause	(s) and manner a	s stated.	
	te Ho 1 24 h Te Fui bletely	Medical	(Check only 2 ☐ <b>Ne</b> one)	lical Exami	iner: On the bas and manne	is of examina	tion and/or in	vestigation, in my	opinion, death oc	curred at the time	, date a	ind place, and du	e to the caus	e(s)
	To th withir To th	Me	29b. Signature and title of c	ertifier	. [			29c. Licen	se number		29d. D	ate signed (Mon	th, Day, Year	)
	1			1	was.	}		D5	3691		Mar	ch 10, 2	2008	
	12		30. Name and address of po	rson who co	ompleted cause	of death (Item	23a) (Type,	Print						
			3 3	1.D.		-		l. Bethes	da, Mary	land 20	0852			
	Sta Registr		31. Date filed (Month, Day,	1 20	100	gistrar's Signa		wi						
_					27									